COMMONWEALTH OF AUSTRALIA

Proof Committee Hansard

SENATE

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Estimates

(Public)

THURSDAY, 9 OCTOBER 2025

CANBERRA

BY AUTHORITY OF THE SENATE

[PROOF COPY]

COMMUNITY AFFAIRS LEGISLATION COMMITTEE

Thursday, 9 October 2025

Members in attendance: Senators Allman-Payne, Ananda-Rajah, Antic, Blyth, Bragg, Brockman, Cox, Grogan, Hanson, Liddle, Nampijinpa Price, Payman, Barbara Pocock, David Pocock, Polley, Roberts, Ruston, Sheldon, Steele-John and Waters

HEALTH, DISABILITY AND AGEING PORTFOLIO

In Attendance

Senator Green, Assistant Minister for Northern Australia, Assistant Minister for Pacific Island Affairs, Assistant Minister for Tourism

Senator McCarthy, Minister for Indigenous Australians

Department of Health, Disability and Ageing

Whole of Portfolio

Mr Blair Comley PSM, Secretary

Ms Rachel Balmanno, Chief Operating Officer, Corporate Operations Group

Ms Celia Street, Acting Deputy Secretary, Strategy and First Nations Group

Professor Susan Wearne, Deputy Chief Medical Officer

Professor Michael Kidd, Chief Medical Officer

Ms Kelly Fisher, Chief Budget Officer, Health Systems Strategy Division

Ms Robyn White, Acting First Assistant Secretary, People, Capability and Communication Division

Ms Leanne Ringwood, Assistant Secretary, People, Capability and Communication Division

Ms Jo Hegerty, Assistant Secretary, People, Capability and Communication Division

Mr David Hicks, Chief Financial Officer, Financial Management Division

Mr Craig Chalmers, Assistant Secretary, Financial Management Division

Mr Stewart Munro, Assistant Secretary, Financial Management Division

Ms Olivia Mahn, Acting Assistant Secretary, Financial Management Division

Ms Miriam Moore, Chief Counsel, Legal Division

Ms Chris Johnston, General Counsel, Legal Division

Mr Brian Schumacher, Acting First Assistant Secretary, Digital Transformation and Delivery Division

Ms Fay Flevaras, Chief Digital Information Officer, Chief Digital Information Officer Division

Ms Narelle Smith, Acting First Assistant Secretary, Integrity and Assurance Division

Ms Lisa Tepper, First Assistant Secretary, Information Technology Division

Ms Melinda Turner, First Assistant Secretary, First Nations Health Division

Ms Mardi Stewart, Assistant Secretary, People, Capability and Communication Division

Professor Emily Lancsar, Chief Health Economist

Ms Fifine Cahill, Acting First Assistant Secretary, Public Hospital and Health Reform Division

Ms Gillian Shaw, Assistant Secretary, Public Hospital and Health Reform Division

Mr Ross Hawkins, First Assistant Secretary, Health Systems Strategy Division

Ms Anthea Raven, Assistant Secretary, Health Systems Strategy Division

Outcome 1

Mr Blair Comley PSM, Secretary

Ms Mary Wood, Deputy Secretary, Interim Centre of Disease Group

Ms Penny Shakespeare, Deputy Secretary, Health Resourcing Group

Professor Anthony Lawler, Deputy Secretary, Health Products Regulation Group

Ms Celia Street, Acting Deputy Secretary, Strategy and First Nations Group

Dr Liz Develin, Deputy Secretary, Primary and Community Care Group

Ms Kelly Fisher, Chief Budget Officer, Health Systems Strategy Division

Professor Susan Wearne, Deputy Chief Medical Officer

Professor Michael Kidd, Chief Medical Officer

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

Dr Alex Hains, Head, National Suicide Prevention Office

Mr Robbie Andrews, Acting Director, Office of the Chief Health Economist Division
Ms Helen Grinbergs, First Assistant Secretary, Centre of Disease Control Oversight Division
Ms Genevieve Quilty, First Assistant Secretary, Health Protection Policy and Surveillance Division
Ms Carita Davis, Acting First Assistant Secretary, Health Security and Emergency Management Division
Mr Jacob Madden, Assistant Secretary, Centre of Disease Control Oversight Division
Adjunct Professor Alison McMillan, Chief Nursing and Midwifery Officer
Mr Duncan McIntyre, First Assistant Secretary, Technology Assessment and Access Division
Ms Masha Somi, Assistant Secretary, Technology Assessment and Access Division
Ms Eliza Strapp, First Assistant Secretary, Health Workforce Division
Mr Mike Pope, Acting Assistant Secretary, Health Workforce Division
Ms Natalie Bekis, Assistant Secretary, Health Workforce Division
Mr Nick Morgan, Assistant Secretary, Health Workforce Division
Mr Stewart Webster, Assistant Secretary, Health Workforce Division
Ms Ariane Hermann, Acting First Assistant Secretary, Chronic Conditions and Screening Division
Ms Jessica Pratt, Assistant Secretary, Chronic Conditions and Screening Division
Ms Trish Clancy, First Assistant Secretary, Population Health Division
Ms Karlie Brown, Assistant Secretary, Population Health Division
Mr Mark Roddam, First Assistant Secretary, Primary Care Division
Ms Sarah Sinclair, Assistant Secretary, Primary Care Division
Ms Jo Da Rocha, Assistant Secretary, Primary Care Division
Dr Anna Peatt, First Assistant Secretary, National Immunisation Division
Mr David Laffan, Assistant Secretary, National Immunisation Division
Mr Gavin Matthews, First Assistant Secretary, Mental Health and Suicide Prevention Division
Mr Matthew Short, Assistant Secretary, Mental Health and Suicide Prevention Division
Mr Darius Everett, Assistant Secretary, Mental Health and Suicide Prevention Division
Dr Sophie Davison, Chief Psychiatrist, Mental Health and Suicide Prevention Division
Mr Nick Henderson, First Assistant Secretary, Medicines Regulation Division
Mr Chris Bedford, First Assistant Secretary, Regulatory Practice and Support Division
Ms Tracey Duffy, First Assistant Secretary, Medical Devices and Product Quality Division
Mr Dave Fintan, Acting First Assistant Secretary, Regulatory Legal Services Division
Dr Lisa Kerr PSM, Assistant Secretary, Medical Devices and Product Quality Division
Dr Marcelle Noja, Assistant Secretary, Medical Devices and Product Quality Division
Mr John Jamieson, Assistant Secretary, Medical Devices and Product Quality Division
Ms Hongxia Jin, Assistant Secretary, Medical Devices and Product Quality Division
Dr Xin-Lin Goh, Director, Medical Devices and Product Quality Division
Mr Avinash Clarke, Assistant Secretary, Medicines Regulation Division
Dr Tahli Fenner, Acting Assistant Secretary, Medicines Regulation Division
Dr Daniel Dascombe, Acting Medical Officer, Medicines Regulation Division
Dr Nitin Bagul, Medical Officer, Medicines Regulation Division
Ms Ashley McLachlan-Bent, Acting Assistant Secretary, Regulatory Practice and Support Division
Ms Jennifer Sellars, Director, Regulatory Practice and Support Division
Ms Sarah Syme, Assistant Secretary, Regulatory Practice and Support Division
Ms Danielle Chifley, Acting Assistant Secretary, Regulatory Practice and Support Division
Mr Duncan Young, First Assistant Secretary, Health Economics and Research Division
Ms Fifine Cahill, Acting First Assistant Secretary, Public Hospitals and Health Reform Division

Mr Ross Hawkins, First Assistant Secretary, Health Systems Strategy Division
Ms Melinda Turner, First Assistant Secretary, First Nations Health Division
Professor Emily Lancsar, Chief Health Economist
Ms Gillian Shaw, Assistant Secretary, Public Hospitals and Health Reform Division
Ms Caitlin O'Brien, Acting Assistant Secretary, Public Hospitals and Health Reform Division
Mr Sean Lane, Assistant Secretary, Health Systems Strategy Division
Ms Natasha Ploenges, Assistant Secretary, Health Economics and Research Division
Ms Chantal Jackson, Assistant Secretary, First Nations Health Division
Ms Kayla Jordan, Assistant Secretary, Health Economics and Research Division
Mr Andrew Lalor, Assistant Secretary, Health Economics and Research Division
Mr Thomas Lester, Assistant Secretary, First Nations Health Division
Mr Ben Barratt, Assistant Secretary, First Nations Health Division
Dr Yiyong Cai, Assistant Secretary, Office of the Chief Health Economist Division
Ms Anthea Raven, Assistant Secretary, Health Systems Strategy Division
Ms Kristen Price, Assistant Secretary, Mental Health and Suicide Prevention Division
Mr Ben Mudaliar, Assistant Secretary, Population Health Division
Ms Carita Davis, First Assistant Secretary, Health Security and Emergency Management Division
Mr Stephen Bouwhuis, First Assistant Secretary, Health Protection Policy Surveillance Division
Mr Paul McCormack, First Assistant Secretary, Centre for Disease Control Division
Ms Stefanie Janiec, Assistant Secretary, Integrity and Assurance Division
Ms Aimee Reeves, Acting Assistant Secretary, Integrity and Assurance Division
Ms Stephanie Williams, Assistant Secretary, Health Security Emergency Management Division
Ms Mandy Charleton, Acting Assistant Secretary, Health Security Emergency Management Division
Mr David Ness, Assistant Secretary, Health Security Emergency Management Division
Ms Samira Hassan, Assistant Secretary, Health Security Emergency Management Division

Australian Health Practitioner Regulation Agency

Ms Monica Lambley, Acting Executive Director, Health Regulation
Dr Jamie Orchard, General Counsel
Mr Justin Untersteiner, Chief Executive Officer

Australian Institute of Health and Welfare

Dr Zoran Bolevich, Chief Executive Officer
Ms Louise Gates, Acting Deputy Chief Executive Officer

Australian Radiation Protection and Nuclear Safety Agency

Dr Gillian Hirth, Chief Executive Officer
Mr James Scott, Chief Regulatory Officer
Dr Rick Tinker, Chief Radiation Health Scientist
Mr Ryan Hemsley, Principal Adviser, Nuclear-Powered Submarines
Mr Martin Reynolds, General Counsel
Mr Sjaan Kuiper, Acting Assistant Director, Strategic Engagement
Mr Max Chamberlin, Acting Senior Officer, Strategic Engagement

Australian Technical Advisory Group on Immunisation

Professor Katie Flanagan, Co-Chair

National Blood Authority

Ms Kate McCauley, Deputy Chief Executive Officer
Mr Ben Noyen, Deputy Chief Executive Officer

Adjunct Professor Adriana Platona PSM, Deputy Chief Executive

National Health Funding Body

Mr Shannon White, Chief Executive Officer

Ms Leonie Clemson, Deputy Chief Executive Officer

National Health and Medical Research Council

Professor Steve Wesselingh, Chief Executive Officer

Ms Prue Torrance, General Manager and Chief Operating Officer

Mr Alan Singh, Executive Director

Organ and Tissue Authority

Ms Lucinda Barry AM, Chief Executive Officer

Ms Beci Imbriano, Chief Operating Officer

Ms Brianna Elms, National Manager, Communications and Engagement

Mr Mark McDonald, National Manager, Analytics and Technology

Outcome 2

Mr Blair Comley PSM, Secretary

Dr Liz Develin, Deputy Secretary, Primary and Community Care Group

Professor Susan Wearne, Deputy Chief Medical Officer

Professor Michael Kidd, Chief Medical Officer

Ms Celia Street, Acting Deputy Secretary, Strategy and First Nations Group

Ms Kelly Fisher, Chief Budget Officer, Health Systems Strategy Division

Adjunct Professor Alison McMillan, Chief Nursing and Midwifery Officer

Mr Matthew Williams, First Assistant Secretary, Benefits Integrity Division

Mr David Evenden, Assistant Secretary, Benefits Integrity Division

Mr Luke Bricknell, Assistant Secretary, Benefits Integrity Division

Mr Anthony McEachran, Assistant Secretary, Benefits Integrity Division

Ms Hayley Petrie, Assistant Secretary, Benefits Integrity Division

Ms Brigid Dohnt, Assistant Secretary, Benefits Integrity Division

Mr Duncan McIntyre, First Assistant Secretary, Technology Assessment and Access Division

Ms Masha Somi, Assistant Secretary, Technology Assessment and Access Division

Ms Sarah Norris, Assistant Secretary, Technology Assessment and Access Division

Ms Rebecca Richardson, Assistant Secretary, Technology Assessment and Access Division

Mr Avi Rebera, Assistant Secretary, Technology Assessment and Access Division

Ms Alicia Segrave, Acting Assistant Secretary, Technology Assessment and Access Division

Mr Daniel McCabe, First Assistant Secretary, Medicare Benefits and Digital Health Division

Ms Louise Riley, Assistant Secretary, Medicare Benefits and Digital Health Division

Ms Mary Warner, Assistant Secretary, Medicare Benefits and Digital Health Division

Mr Nigel Murray, Assistant Secretary, Medicare Benefits and Digital Health Division

Ms Renaye Lucchese, Assistant Secretary, Medicare Benefits and Digital Health Division

Mr Simon Cleverley, Assistant Secretary, Medicare Benefits and Digital Health Division

Mr Matthew Castle, Assistant Secretary, Medicare Benefits and Digital Health Division

Associate Professor Andrew Singer, Principal Medical Officer, Medicare Benefits and Digital Health Division

Mr Jacob Grooby, Director, Medicare Benefits and Digital Health Division

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

Mr Ross Hawkins, First Assistant Secretary, Health Systems Strategy Division

Ms Melinda Turner, First Assistant Secretary, First Nations Health Division

Mr Brian Kelleher, Assistant Secretary, Health Systems Strategy Division
Mr Paul McBride, Assistant Secretary, Health Systems Strategy Division
Dr Yiyong Cai, Assistant Secretary, Office of the Chief Health Economist Division
Dr Daniel Chaston, Director, Technology Assessment and Access Division
Ms Anna Huckstepp, Acting Assistant Secretary, Benefits Integrity Division
Professor Emily Lancsar, Chief Health Economist
Ms Kate Hyson, Acting Assistant Secretary, Benefits Integrity Division
Ms Ariane Hermann, Acting First Assistant Secretary, Chronic Conditions and Screening Division
Ms Jessica Pratt, Assistant Secretary, Chronic Conditions and Screening Division

Australian Digital Health Agency

Ms Amanda Cattermole PSM, Chief Executive Officer
Ms Joanne Greenfield, Chief Operating Officer
Mr John Borchi, Chief Technology Officer
Mr Paul Creech PSM, Chief Program Officer
Mr Peter O'Halloran, Chief Digital Officer

Outcome 3

Mr Blair Comley PSM, Secretary
Ms Sonja Stewart, Deputy Secretary, Ageing and Aged Care Group
Professor Susan Wearne, Deputy Chief Medical Officer
Professor Michael Kidd, Chief Medical Officer
Ms Emily Harper, First Assistant Secretary, Market and Workforce Division
Ms Genevieve Donnelly, Assistant Secretary, Market and Workforce Division
Ms Shonella Tatipata, Assistant Secretary, Market and Workforce Division
Ms Eleanor Browne, Assistant Secretary, Market and Workforce Division
Ms Jessica Evans, Assistant Secretary, Market and Workforce Division
Ms Cathy Milfull, Acting Assistant Secretary, Market and Workforce Division
Ms Megan Lancaster, Assistant Secretary, Market and Workforce Division
Mr Travis Power, Assistant Secretary, Market and Workforce Division
Ms Lauren Hendriks, Acting Assistant Secretary, Market and Workforce Division
Ms Trish Garrett, First Assistant Secretary, Service Delivery Division
Ms Emma Parker, Acting Assistant Secretary, Service Delivery Division
Ms Cassie Mason, State Manager, Service Delivery Division
Ms Amy Laffan, First Assistant Secretary, Quality and Assurance Division
Ms Naomi Lavithis, Acting Assistant Secretary, Quality and Assurance Division
Ms Ingrid Leonard, Assistant Secretary, Quality and Assurance Division
Ms Katie Holm, Assistant Secretary, Quality and Assurance Division
Mr Robert Day, Assistant Secretary, Quality and Assurance Division
Ms Chamandeep Chehl, Assistant Secretary, Quality and Assurance Division
Mr Joshua Maldon, First Assistant Secretary, Reform Implementation Division
Mr Toby Burgess, Assistant Secretary, Reform Implementation Division
Ms Emma Cook, Assistant Secretary, Reform Implementation Division
Ms Maria Filardo, Acting Assistant Secretary, Reform Implementation Division
Mr Greg Pugh, First Assistant Secretary, Access and Home Support Division
Ms Jasmine Snow, Acting Assistant Secretary, Access and Home Support Division
Ms Julia Atkinson, Acting Assistant Secretary, Access and Home Support Division

Ms Rachel Blackwood, Assistant Secretary, Access and Home Support Division
Ms Aimee Chambers, Assistant Secretary, Access and Home Support Division
Ms Susan Trainor, Acting First Assistant Secretary, Residential Care Division
Mr Mark Shen, Acting Assistant Secretary, Residential Care Division
Ms Alice Creelman, Assistant Secretary, Residential Care Division
Ms Melinda Turner, First Assistant Secretary, First Nations Health Division
Mr Andrew Campbell, Acting Assistant Secretary, Residential Care Division
Ms Erika Barnett, Acting Assistant Secretary, Reform Implementation Division
Mr Mark Richardson, Assistant Secretary, Residential Care Division
Mr Greg Keen, Assistant Secretary, Reform Implementation Division
Mr Nikolai Tsyganov, Assistant Secretary, Reform Implementation Division
Mr Brian Schumacher, Acting First Assistant Secretary, Digital Transformation and Delivery Division
Ms Kelly Fisher, Chief Budget Officer, Health Systems Strategy Division
Ms Jo Hegerty, Assistant Secretary, People, Capability and Communication Division

Aged Care Quality and Safety Commission

Ms Liz Hefren-Webb, Commissioner
Mr Mark le Dieu, Deputy Commissioner, Corporate
Dr Mandy Callary, Chief Clinical Adviser
Mr Peter Edwards, Deputy Commissioner, Clinical and Specialist Support
Mr Gary Rake, Deputy Commissioner, Regulatory Operations
Ms Bronwen Jaggers, Executive Director, Engagement, Education and Communication
Ms Michelle Bampton, Interim Complaints Commissioner

Independent Health and Aged Care Pricing Authority

Professor Michael Pervan, Chief Executive Officer

Office of the Inspector-General of Aged Care

Ms Natalie Siegel-Brown, Inspector-General of Aged Care
Ms Lisa Berry, Acting Agency Executive Director

Outcome 4

Mr Blair Comley PSM, Secretary
Mr Luke Mansfield, Acting Deputy Secretary, Disability and Carers Group
Professor Susan Wearne, Deputy Chief Medical Officer
Professor Michael Kidd, Chief Medical Officer
Dr Liz Develin, Deputy Secretary, Primary and Community Care Group
Ms Kelly Fisher, Chief Budget Officer, Health Systems Strategy Division
Ms Hope Peisley, Acting First Assistant Secretary, Disability and Carer Programs Division
Ms Suzanne Muir, Assistant Secretary, Disability and Carer Programs Division
Ms Lydia Ross, Assistant Secretary, Disability and Carer Programs Division
Ms Jodi Cassar, Acting First Assistant Secretary, Disability Reforms and Royal Commission Division
Ms Lisha Jackman, Assistant Secretary, Disability Reforms and Royal Commission Division
Ms Melissa Catania, Acting Assistant Secretary, Disability Reforms and Royal Commission Division
Mr Ross Schafer, First Assistant Secretary, NDIS Markets and Safeguards Division
Dr Louise O'Rance, Assistant Secretary, NDIS Markets and Safeguards Division
Mr Alexander Abel, Assistant Secretary, NDIS Markets and Safeguards Division
Ms Natasha Shahidullah, Acting Assistant Secretary, NDIS Markets and Safeguards Division
Mr James MacIsaac, First Assistant Secretary, NDIS Participants and Performance Division

Ms Nerissa Stewart, Acting Assistant Secretary, NDIS Participants and Performance Division

Mr Chris Early, Acting Assistant Secretary, NDIS Participants and Performance Division

Ms Sarah Hawke, Assistant Secretary, NDIS Participants and Performance Division

Ms Emily Clay, Acting Assistant Secretary, NDIS Participants and Performance Division

National Disability Insurance Scheme

Mr Scott McNaughton, Acting Chief Executive Officer, National Disability Insurance Agency

Mr Samuel Porter, Deputy Chief Executive Officer, Enabling Services, and Chief Operating Officer, National Disability Insurance Agency

Ms Penelope McKay, Deputy Chief Executive Officer, Partners, Providers and Home and Living, National Disability Insurance Agency

Mr John Dardo, Deputy Chief Executive Officer, Integrity Transformation and Technology Service, National Disability Insurance Agency

Mr Aaron Verlin, Acting Deputy Chief Executive Officer, Service Design and Improvement, National Disability Insurance Agency

Mr Andrew Maitland, Acting Deputy Chief Executive Officer, Service Delivery, National Disability Insurance Agency

Dr Janine Mohamed, Deputy Chief Executive Officer, First Nations, National Disability Insurance Agency

Ms Amity Durham, Deputy Chief Executive Officer, Children, Specialised Services and Scheme Interfaces, National Disability Insurance Agency

Mr David Gifford, General Manager, Scheme Actuary and Chief Data Officer, National Disability Insurance Agency

Mr Chris Breitkreuz, Chief Financial Officer, National Disability Insurance Agency

Mr Daniel Flowers, Acting General Manager, Reviews and Information Release, National Disability Insurance Agency

Ms Fleur Hill, General Manager, SA, WA, NT Regional and Remote Services, National Disability Insurance Agency

NDIS Quality and Safeguards Commission

Ms Louise Glanville, Commissioner

Ms Natalie Wade, Associate Commissioner

Ms Catherine Myers, Deputy Commissioner, Regulatory Operations (Registrar)

Ms Sian Leathem, Deputy Commissioner, Complaints and Engagement

Ms Alisa Chambers, Deputy Commissioner, Regulatory Policy, Insights and Review

Ms Laura Sham, Deputy Commissioner, Data and Regulatory Transformation

Ms Tina Daisley, Deputy Commissioner, People and Culture

Mr Rod Carracher, Deputy Commissioner, Practice Quality Division

Mr Stephen Rees, Director, Parliamentary Services

Ms Martha Arkalis, Director, Office of the Commissioner and Associate Commissioner

Committee met at 09:01

CHAIR (Senator Cox): I declare open this hearing of the Community Affairs Legislation Committee into the 2025-26 supplementary budget estimates. I begin by acknowledging the traditional custodians of the land on which we meet today and pay my respects to their elders past and present. I extend that respect to all Aboriginal and Torres Strait Islander people here today.

The committee has fixed Friday 28 November 2025 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 Thursday 16 October 2025. The committee's proceedings today will begin with the Department of Health, Disability and Ageing whole-of-portfolio and corporate matters.

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. 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 for questions at Senate 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 Senate estimates hearings. I remind all 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 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 interest immunity statement into the *Hansard*.

The extract read as follows—

Public interest immunity claims

That the Senate—

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

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

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

(1) If:

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

(b) an officer of the department or agency to whom the request is directed believes that it may not be in the public interest to disclose the information or document to the committee, the officer shall state to the committee the ground on which the officer believes that it may not be in the public interest to disclose the information or document to the committee, and specify the harm to the public interest that could result from the disclosure of the information or document.

(2) If, after receiving the officer's statement under paragraph (1), the committee or the senator requests the officer to refer the question of the disclosure of the information or document to a responsible minister, the officer shall refer that question to the minister.

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

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

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

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

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

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

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

(13 May 2009 J.1941)

(Extract, Senate Standing Orders)

CHAIR: I remind senators of their obligations under the Behaviour Code for Australian Parliamentarians to treat witnesses with dignity, courtesy, fairness and respect.

Department of Health, Disability and Ageing

[09:04]

CHAIR: I now welcome Senator the Hon. Malarndirri McCarthy, Minister for Indigenous Australians, representing the Minister for Health, Disability and Ageing. Minister, do you wish to make an opening statement?

Senator McCarthy: Thank you, Chair. I too would like to acknowledge the traditional owners of this country and pay my respects to elders past, present and emerging, and thank the committee in advance in terms of Closing the Gap outcomes. It is critical that, whilst we look at health in the broad for all Australians, I am very pleased to see that Closing the Gap health outcomes will also be in this section. I acknowledge history being made today with you as chair, an Indigenous woman from Western Australia. Congratulations.

CHAIR: Thank you, Minister. I now welcome the secretary of the Department of Health, Disability and Ageing, Mr Blair Comley. Mr Comley, do you wish to make an opening statement?

Mr Comley: No, thank you, Chair.

CHAIR: I now call officers of the Department of Health, Disability and Ageing in relation to the whole of portfolio and corporate matters. I will start with Senator Ruston.

Senator RUSTON: Thank you for the information you've provided. It's always very difficult when you get it the morning of the hearing. We asked for it on Tuesday. Unfortunately, it will take me a while to be able to prosecute some of the information you provided, but thank you. In the interests of understanding, I have a question in relation to a constituent of mine who has given me permission to discuss his case publicly. It relates to a DSOA entitlement. It also relates to an ACAT assessment that he believes has been wrongly put in place. I'm interested to understand because it crosses over between the department of health and health in terms of DSOA as opposed to ACAT for ageing or aged care. Where would you be suggesting that I ask the questions?

Mr Comley: Obviously, we are always cautious about talking about an individual.

Senator RUSTON: He has given me his permission. He is watching at the moment. He wants to be

Mr Comley: Well, he hasn't given—

Senator RUSTON: I will provide that to you. I can ask him if he would write to you and give you permission as well.

Mr Comley: Well, I think that would be the first step we would have to take. We would have to have written permission from that person. Even then, we need to be cautious. Talking about an individual in this forum is very difficult. We might have part of the information provided in this session. There might be a lot of other information, and there may not necessarily be consent to the release of all that information. I think the appropriate time to raise that would be, in the first instance, in the aged-care segment, which is later today.

Senator RUSTON: I will get him to send you a message to say that it's okay to actually speak about him. In the absence of that, I'm more interested to talk about the process that has occurred and to seek your understanding as to why this issue has continually failed to be remedied despite the fact that the ombudsman said that he was in the right and the department was in the wrong. Would that be outcome 1 or outcome 2?

Mr Comley: No. It's outcome 3.

Senator RUSTON: So aged care?

Mr Comley: Aged care, yes.

Senator RUSTON: So DSOA comes under aged care?

Mr Comley: Disability support is actually outcome 4. I suggest that we start, if there is an ACAT assessment involved, in outcome 3, which is aged care. Outcome 4 is actually coming before the committee tomorrow. We can at least understand the aged-care dimension to it through ACAT in outcome 3. If they could provide that consent and we know the circumstances, we may be able to be more helpful. I stress that we are very cautious about talking about individual cases.

Senator RUSTON: That's absolutely fine. This has been going on for some time. This man is likely to die before you resolve this case. He and I have tried every course of action to try to get this remedied. I will allow you to make the judgement as to what you choose, clearly.

Since the election, have you got a number in terms of the changes of ASL in the department?

Ms Balmanno: The current headcount of the department as of 31 August is 7,478.

Senator RUSTON: Is that an increase since the election in any way?

Ms Balmanno: Yes. That is an increase since the end-of-June figure.

Senator RUSTON: How much is the increase?

Ms Balmanno: It is 348 since 30 June.

Senator RUSTON: What about the 30th? Have you got the numbers since May?

Ms Balmanno: No, I don't have that in front of me.

Senator RUSTON: Would it be possible for you to give us an update from May and a brief outline about the main areas that additional staff have been appointed into?

Ms Balmanno: Yes.

Senator RUSTON: How many disability staff have been relocated into the department of health and aged care?

Ms Balmanno: I should note that headcount increase includes the staff in disability and the reduction due to the staff from Sport leaving the portfolio.

Senator RUSTON: Can you give us a bit of an in-and-out map? That would be great.

Ms Balmanno: Yes.

Senator RUSTON: Have any agencies moved out of the health, disability and ageing department since the election? Sport?

Ms Balmanno: Sport. The part of the department that looks after sport, the National Sports Tribunal and the other sports agencies.

Senator RUSTON: That has been mogged to communications?

Ms Balmanno: Infrastructure. Infrastructure is the first word.

Mr Comley: That includes all the sport agencies—the Australian Sports Commission, the Australian Sports Foundation and the tribunal. I think I may have missed one.

Ms Balmanno: There's one more.

Mr Comley: There are the four agencies that are sport related.

Senator RUSTON: Was there a rationale provided for that mogging, apart from just that the minister happened to be going there?

Mr Comley: When sport was in the health portfolio, it was probably focusing as much on the link to preventive health and activity. It is true, though, that there are a lot of infrastructure projects associated with sport at the local level. For example, there is the Play Away Program, which followed on from the Matildas. There is the lead-up to the 2032 Olympics and 'the green and gold decade'. It's one of those classic ones where there are arguments for it to be in Health and there are arguments for it to be in Infrastructure.

Senator RUSTON: My question is: was there a rationale?

Mr Comley: That was the rationale.

Senator RUSTON: Is it in a written sense, in terms of a briefing document that actually explained why we had deprioritised sport for participation in a health context for building some change rooms?

Mr Comley: I'm not sure. Certainly, from my conversations with the teams that left, we are not deprioritising that. We're going to keep links. It's always the case with machinery-of-government changes that you can't co-locate everything in one department. Therefore, you need to coordinate across government to make sure that those links are maintained on an ongoing basis.

Senator RUSTON: Have any ASLs gone to any other departments apart from the mogging of the sport portfolio group?

Ms Balmanno: No, Senator.

Mr Comley: No.

Senator RUSTON: Do you have a key priority, at least in terms of what you want to achieve in Health in this parliamentary term?

Mr Comley: Senator, there are two-—

Senator RUSTON: To that end, have we got an annual report yet?

Ms Balmanno: No, Senator. We haven't finalised our annual report yet.

Senator RUSTON: When are you supposed to have it finalised by?

Ms Balmanno: By the end of October.

Senator RUSTON: So that will be done?

Ms Balmanno: Yes, Senator.

Mr Comley: The way I would answer that question is that it depends on what you mean by our priorities as a department or government. We provided an incoming government brief to the government, as is standard across the Public Service. That incoming government brief was subject to FOI. A substantial proportion of that incoming government brief was released. That incoming government brief pointed to five key pillars of activity over the next term and beyond of government priority. The first is strengthening Medicare. That is trying to deliver accessible and affordable Medicare.

Senator RUSTON: Strengthening Medicare is a headline. What does success look like for strengthening Medicare in the department's KPIs or what you're trying to deliver?

Mr Comley: Again, we'll come back to it. That was one of five. There were also some others that we hadn't put in the pillars but that are in fact ongoing activities. I am going to come back to your question. I'm not trying to avoid it. The five things didn't include, for example, the ongoing work on aged care. When that incoming government brief was prepared, we weren't aware that Disability was going to be brought into the portfolio. That incoming government brief was separate from the incoming government brief for Disability.

The answer to strengthening Medicare is twofold. The first is we actually have a range of KPIs that come through the performance statements, which are prepared and then audited by the ANAO. They put two issues that go to strengthening Medicare. On top of that, we would track access and affordability to Medicare as key metrics for the department.

Senator RUSTON: I'm trying to understand this parliamentary term's goals. If you were going to say to the Australian public that, for the Department of Health, Disability and Ageing, the goals for this parliamentary term are (1), (2), (3), (4) and (5), what would you say they are?

Mr Comley: I would go back to the incoming government brief and talk about access and affordability for strengthening Medicare. One key metric would be outcomes on bulk-billing rates. Another key metric would be the proportion of Australians who report that they were unable to access medical care because of costs. They would be the two obvious ones I would point to.

The second pillar that we had in that incoming government brief was cheaper and better medicines available. A key metric we would be looking at is things such as co-payments and out-of-pocket expenses for medicines. We would also be looking at the availability of medicines. That would go in part to the rollout of the health technology assessment review and the implementation of that to ensure that the right medicine is available in Australia.

Senator RUSTON: We'll get to that.

Mr Comley: The third pillar that was outlined in the incoming government brief was ensuring that we have the right health workforce and that they are working to the top of their scope of practice. We will be monitoring, obviously, numbers of key professionals—in particular but not exclusively GPs—and the distribution of that workforce. We will also be looking at how we track whether health professionals are working-—

Senator RUSTON: We are limited in terms of time. I am keen to understand how you measure this. Where are these measures going to be delivered? What is your success? You've said GPs in DPAs. What is your measure of success? How many GPs? When? Where? Are those sorts of things able to be provided?

Ms Balmanno: Yes.

Senator RUSTON: Is it possible for those-—

Ms Balmanno: They are published in our annual report. The indicators themselves are in the portfolio budget statement for the current budget. The results against those indicators will be part of our annual report.

Senator RUSTON: So they will actually be the targets in your annual report?

Ms Balmanno: Yes, Senator.

Senator RUSTON: And the times for those targets? I don't need to waste any more of your time outlining them. We'll wait for the annual report and talk to you about it in December.

Ms Balmanno: I have those numbers for you, Senator, in terms of the ons and offs since June. The MOGs out show that a headcount of 79 people left the department.

Senator RUSTON: And that was Sport?

Ms Balmanno: That was Sport. That's just from the department, not the separate agencies. The staff coming in with Disability and carers was 496.

Senator RUSTON: In terms of health and aged care, there has not really been any substantive change?

Ms Balmanno: A small reduction.

Senator RUSTON: What has been the expenditure of the department on advertising in relation to strengthening Medicare?

Ms Balmanno: Particularly in relation to some of the campaign work that has happened?

Senator RUSTON: Yes.

Ms Ringwood: The expenditure on the Medicare benefits campaign in the last financial year-—

Senator RUSTON: Did you call it the Medicare benefits campaign?

Ms Ringwood: Yes.

Ms Balmanno: That's our working title.

Ms Ringwood: That's our working title for the campaign. The spend on that campaign was $14.5 million.

Senator RUSTON: Does that include things such as the website and the like, or is that external expenditure on your billboards and legacy media?

Ms Ringwood: That doesn't include work on the website. That is done internally. That expenditure is on things such as research, creative development and media placement.

Senator RUSTON: In terms of the website particularly, the wording on the website was 'Getting stronger after 40 years'. Why did the department use that wording?

Ms Balmanno: Are we talking about the old website?

Senator RUSTON: Yes, we are at this stage.

Ms Balmanno: That was a website that was active during the 40th anniversary of Medicare.

Senator RUSTON: Okay. That website then changed its wording to 'Strengthening Medicare'. When did that website change from 'Getting stronger after 40 years' to 'Strengthening Medicare'? What date?

Ms Balmanno: I would have to take the exact date on notice, Senator.

Senator RUSTON: It appears it was some time in late March, early April. Would it be possible to determine that reasonably quickly?

Ms Ringwood: We will see what we can find out for you, Senator, and see when we can come back to you.

Senator RUSTON: What was the basis of the decision to change from 'Getting stronger after 40 years' to 'Strengthening Medicare'? What was the process that took place to make that decision?

Ms Balmanno: I would have to take that on notice. It's part of the regular website update process. It would probably be to do with the timing of the 40th anniversary and where we were at in terms of any live campaign activity.

Senator RUSTON: Would it be possible to get any correspondence or communications between the minister's office and the department in relation to changing that website to 'Strengthening Medicare' and the process of moving from 'Getting stronger after 40 years', which was the working title of that website for quite some time? It changed to 'Strengthening Medicare' in March or April this year.

Ms Balmanno: We can check what there is.

Senator RUSTON: Any correspondence or communication. There's a whole heap of statistics on 'Getting stronger after 40 years'. Is there any way you can provide us information as to why the particular timeframes were used? As an example-—

Ms Balmanno: We have covered that at estimates before.

Senator RUSTON: But we never actually got the answer to it. I would be keen for you—now you've had time to have a bit of a think about it. It's not like the term of this government is just some arbitrary time that was chosen in that. If I go to that website today, 'Strengthening Medicare' doesn't come up any more. It appears to go to something called 'About Medicare'. Is there a different Google search on it or whatever? If you put in the same thing, previously it would come up with 'Getting stronger after 40 years'. It then changed just as you were going into caretaker mode to 'Strengthening Medicare'. Quite coincidentally, that also happened to be the government's

campaign slogan in relation to their health policy promotion. When you go on there now, it comes back with the old department of health standard with the non-Medicare brand. It just says 'About Medicare'.

Ms Balmanno: The website has always had the 'About Medicare' content. That gets updated as new changes come through. The other content was related to two particular things-—the 40th anniversary and the campaign activity that Ms Ringwood talked about.

Senator RUSTON: I'm keen to understand-—

Ms Balmanno: Whenever we have a campaign, we have a campaign site that presents information relevant to that campaign and the campaign materials. It helps consumers to easily find additional information about that topic.

Senator RUSTON: Quite coincidentally, Ms Balmanno, the Strengthening Medicare campaign that was on your website prior to the election and during the election campaign and post the election campaign for a small period of time completely and utterly replicated the campaign imagery and messaging of the Labor Party. Subsequent to that, it has now returned to what it was prior to that. You just referred to how you update and do things when campaigns are being run.

Ms Balmanno: Yes.

Senator RUSTON: This looks to me very much like the department was mirror imaging what the government was doing during an election campaign. Your promotional activity looks exactly the same as the government's election campaign material. You changed it at the same time that the government went into election campaign mode. This looks to me very much like the department was actually actively coerced or asked to make your departmental communications reflect what the government did. I'm not saying you did it. I'm just saying that's what it looks like here. Can you provide me with a paper trail to show why you chose to do this, incredibly coincidentally, at the same time the government were actually in election mode, when they shouldn't have been using the Medicare logo? I will ask Services Australia about that tomorrow. Can you defend the fact that the department was replicating the government's election campaign at the same time?

Ms Balmanno: The department did not replicate the government's election campaign. The department ran a campaign that went through all the usual clearance processes.

Senator RUSTON: Could you provide that for me?

Ms Balmanno: That included creative development and the approval of those creative materials. It included the use of the Medicare brand. That is the campaign that was run. When the election started, as with all of our campaigns, the campaign material was removed from all channels.

Senator RUSTON: And you will be able to provide me with that?

Ms Balmanno: Yes, Senator, to the extent that the cabinet rules allow. Clearances are to be provided.

CHAIR: I'm sorry to interrupt. Senator Ruston, how much longer do you need on this call? I will share the call with Senator Steele-John. He wants some clarification-—

Senator RUSTON: Sure, please. I'm happy to withdraw.

CHAIR: if that's okay. Thank you.

Senator STEELE-JOHN: Good morning, everybody. It's good to see you. I have some questions about the outcomes of the last health ministers forum meeting. I get the sense that this might be actually the best place to ask them. The outcomes that I'm interested in exploring cross a few different areas. Do you think it would be the appropriate place to ask them here in the day?

Mr Comley: Subject to guidance from the chair, I'm happy for you to ask the questions. Then we can work out whether it is the right place. Obviously, the Health Ministers Meeting is broad ranging at one level, but each item is quite specific.

Senator STEELE-JOHN: That's why I wondered. It goes to the question of ADHD diagnosis and prescribing. The last forum resulted in a communique that stated clearly that there was an intention to develop nationally consistent guidelines for diagnosis and prescribing in relation to ADHD and a commitment to commission the development of a nationally consistent set of rules. My first question is: who will be developing these rules?

Mr Comley: I am just thinking. It's probably outcome 1.

CHAIR: Which we are moving to.

Mr Comley: After this. It's not cross-portfolio and it's not a corporate issue. That would come up in outcome 1. We can alert people to make sure that they are ready when they come for that.

Senator STEELE-JOHN: That clarifies that, Chair. Thanks very much.

CHAIR: That was short and sweet. Thank you for facilitating that. Senator Ruston, I'll hand the call back to you.

Senator RUSTON: Just quickly, I will finish on this. Could you provide me with the complete timeline in relation to the 40th anniversary and Strengthening Medicare. I just googled now to search for the URL. It actually says 'Page not found'. The Strengthening Medicare page has just disappeared. If you could let me know when it disappeared, that would be terrific. Is it possible to get that today? This is looking awfully like political manipulation. Does the minister approve these campaigns, or does he have no knowledge whatsoever of a campaign? It is $14.5 million as well as whatever you've spent internally on this campaign. What is the process in relation to the minister's involvement in any decision-making?

Ms Balmanno: It's the same as it has been for many successive governments, where there is a government approval process for content, expenditure and the actual campaign materials.

Senator RUSTON: So the minister approved this campaign?

Ms Balmanno: The government approves the campaign.

Senator RUSTON: The government. It is a cabinet process?

Ms Balmanno: Yes.

Mr Comley: I will just add, though, Senator, because I'm familiar with this, that there is also an approval process where I, as secretary, have to sign off on any campaign to attest that it meets the government communication guidelines. In that process, I receive attestations. The comms people can give the full list. There's a legal clearance. There's information on how campaigns are tested with target audiences to see whether they are actually effective.

Ms Balmanno: And the advice of the independent communications committee informs that.

Senator RUSTON: I'm only asking about the timing. The timing is just so wildly coincidental—that this was up and running as a campaign during the election period and now it's gone. So it wasn't up before. It's not up now.

Ms Balmanno: The campaign was not operational during the caretaker period.

Senator RUSTON: If I went on to that website during the election campaign, it would not have been 'Strengthening Medicare'?

Ms Balmanno: The phrase 'strengthening Medicare' might have been used because it was used in quite a number of policy decisions and announcements prior to the election. But the campaign materials were not on the website during the caretaker period.

Senator RUSTON: So the 'Strengthening Medicare' website was previously 'Getting stronger after 40 years'. That change to 'Strengthening Medicare' was taken down before the campaign started? Is that what you are just telling me?

Ms Balmanno: The campaign website was not active during the caretaker period.

Senator RUSTON: So you are telling me that the website-—

Ms Balmanno: The department still had information about government policies and programs, including, obviously, Medicare.

Senator RUSTON: I would really like the timeframe.

Ms Balmanno: Yes, Senator.

Senator RUSTON: I would really like to understand the communications that occurred with the minister. You don't necessarily have to tell me what they were.

Ms Balmanno: Yes, Senator.

Senator RUSTON: It is in terms of the approval process and when the cabinet approval process occurred. I'm not asking you what it was but when it occurred. As I said, this looks awfully like the department was replicating the government's election campaign.

Senator BLYTH: I have a couple of follow-up questions. This is probably something you'll have to take on notice. How many specialised campaigns has Medicare run in the last four years in total? We've got strengthening Medicare. We've got the 40th anniversary. How many specialised campaigns?

Ms Ringwood: The 40th anniversary was not an advertising campaign.

Ms Balmanno: There is quite a formal definition of campaigns in terms of the Australian government's communications guidelines.

Ms Ringwood: I would have to take that on notice. There have obviously been campaigns run to support the urgent care clinics program. There have been two phases of that campaign run today.

Senator BLYTH: And then if we could find out exactly how much has been spent on each of these, I guess, micro campaigns, or whatever you would call them, that would be really helpful as well. I think that $14.5 million amount didn't include the website?

Ms Balmanno: No. We do our website work internally.

Senator BLYTH: I guess it still costs the taxpayer, because they are paying for that. It would be good to get a number for that as well.

Ms Balmanno: I don't believe that website development is something we can separate out. But for the other costs that you've mentioned, absolutely. For the other campaign type activities, yes.

Senator BLYTH: Have a go. You would have to have some kind of idea. Private businesses have to know how much they are spending on website development and so forth.

Ms Balmanno: We do. But it would be for all of the department's website.

Senator BLYTH: But every time you change something, there would be graphics. I'm sure it's-—

Ms Balmanno: Which we do internally. We have teams that do that work.

Senator BLYTH: I understand that. You still have to pay those teams. You would apportion a certain amount of their work time to it. With graphic design, they would keep hours of what they are spending on each project, surely.

Ms Balmanno: I don't think we would be able to disaggregate the time of the teams for our graphic design or our web teams.

Senator BLYTH: Can you give us a costing for work costs?

Ms Balmanno: We don't have a chargeback model. We don't have a-—

Senator BLYTH: Okay. If you have a graphic design team and a web team, what does it cost to have those teams per annum?

Ms Balmanno: Certainly.

Senator BLYTH: That would be helpful.

Senator RUSTON: Finally, on this issue, there is the information contained on this website. I know that we did traverse some of this at the last estimates. I draw your attention to the national bulk-billing rate graph that was on that page that now has disappeared. I assume, Mr Comley, you're the one who has to sign off ultimately on the government's own advertising guidelines. Under 'Presented in an objective, fair and accessible manner', in terms of the information, it says:

In demonstrating compliance with this Principle considerations include:

… … …

- The basis of factual comparisons is clear and does not mislead the recipient about the situation;

In your graph, you start at this arbitrary date of July 2023. Would you concede that in July 2022 the bulk-billing rate was 88 per cent?

Mr Comley: We are happy to have a conversation and get people to the table to talk about bulk-billing rates at particular periods of time.

Senator RUSTON: That's not what I'm asking for. In the advertising guideline principles, it says that you need to provide information in a way that you can make an objective assessment. I would contend that anybody reading that graph would look at that and say, 'Wow, there has been a significant increase in bulk-billing rates.' Yet if you had put the graph out to a year prior to that, you would have seen a plummeting of bulk-billing rates in that period of time. For some reason, you've made a decision to start using data from a period where, if you look at it, you think it looks alright. If you had shown it from a year previously, you would have seen that it was absolutely plummeting. I'm just keen to understand when you, as the person who signs off on this ultimately, believed that this met the guidelines of providing clear information that does not mislead the recipient about the situation.

Mr Comley: Again, if it's part of the campaign, I sign off and I get attestations from people who look at every detail to say that it is. Over time, lots of data is presented with different periods. That's not unusual. It's a matter of judgement. I don't think that's misleading.

Senator RUSTON: Once again, the fact is that you were running a campaign prior to the election period that was the exact same campaign that the government then chose to run as their election campaign. You contend that is just a coincidence?

Mr Comley: I won't use your words. We followed our usual process of what we thought was appropriate to put on our website and have in a campaign, with all the usual checks and balances. I think that was done appropriately.

Senator RUSTON: Thank you. I'm sure that I will contend that it doesn't look like that. When you provide that information, maybe you will be able to show me the independent process that you went through.

Ms Balmanno: Yes.

Senator RUSTON: With no influence by the government.

CHAIR: Thank you, Senator Ruston. We will now move to outcome 1. We are heading to health policy, access and support and cross-portfolio Indigenous matters for the first time.

[09:38]

CHAIR: I now call officers from the Department of Health, Disability and Ageing in relation to outcome 1, health policy, access and support and invite questions.

Senator STEELE-JOHN: I will have a crack at the ADHD piece. We have had a meeting of the national health ministers. That meeting resolved to commission nationally consistent guidelines in relation to diagnosis and prescription for ADHD. I would like to know first of all who will be developing these rules.

Prof. Lawler: As the secretary highlighted earlier this morning, this isn't a cross-portfolio matter, but it is a matter that engages a number of different groups within the Department of Health, Disability and Ageing. As previously discussed, when I was simultaneously in the role of Chief Medical Officer and deputy secretary of health products regulation, we took on the role of consulting with key stakeholders, including states, territories and peak bodies and medical colleges, around the current landscape. That included matters such as what the prescribing process is; what the authority to become a prescriber in jurisdictions is; what medicines are allowed to be dispensed and in what quantities; and what cross-border arrangements are in place, which is particularly important not only for places such as Tasmania and the Northern Territory but also of course when you're living in a border area. We found significant variance in practice. We also found that there was a real willingness from the states and territories to, in many instances, liberalise access. Of course, this is an issue of balancing safety and quality versus the ability to access treatment.

It was a very useful conversation. It gave us the ability to understand the landscape. We've incorporated that and, as you mentioned, advised the health ministers meeting on the matters that do relate. What has come of that in terms of the communique you've cited is that there was an acknowledgement of the reforms already announced by several jurisdictions. There was an endorsed need for national harmonisation of ADHD diagnosis and prescribing practices. There had been work commissioned to develop nationally consistent rules, with a progress report to be provided at the next HMN. The challenge, of course, is that this is happening at the same time as a number of other scope of practice pieces of work. I have at the table with me Eliza Strapp, who might be able to add to that.

Ms Strapp: As Professor Lawler just outlined, we are undertaking a range of things around scope of practice for health professionals. As part of that, it came out of the scope of practice review undertaken by Mark Cormack last year. Part of that was a recommendation around harmonisation of drugs and poisons legislation. As part of this and as detailed in the communique on health ministers, we are working with our state and territory colleagues. Part of that work is, I think, fast-tracking the ADHD work to make consistent how we diagnose and prescribe different ADHD medication and other medicines to ensure that our health workforce is working to its full scope of practice.

Senator STEELE-JOHN: Just to be clear, it says that there has been work commissioned. Who specifically has been commissioned to do that work?

Ms Strapp: It's a joint piece of work among all the states and territories. The Commonwealth is setting up a working group. It doesn't just sit with, I guess, one area in the jurisdictions. We're setting up a working group that will be working across health departments. The Commonwealth is leading the set-up of that work. It is working in conjunction with the Health Workforce Taskforce. That is a subgroup of the Health Chief Executives Forum.

Senator STEELE-JOHN: When will that working group be established?

Ms Strapp: I believe we're in the process of setting it up. I'm hopeful that it will be this month, Senator.

Senator STEELE-JOHN: When will they complete their work? When are they expected to complete their work?

Ms Strapp: I think we want to fast-track the ADHD work as an example. We've got to come back to the health ministers with an update in October. I think a lot of work has already been undertaken. We've got some good examples from the states and territories, which are ahead of doing things. We want to build on what has already happened. As Professor Lawler just talked about, a lot of work has happened across jurisdictions. Obviously, this does mean updating legislation. If you look at where each state and territory is up to at the moment, you see that they are at varying levels. Some haven't yet legislated to change who can prescribe. I think we probably need to take stock of where things are up to. We have to report back in December. I acknowledge that we want to fast-track the ADHD work ahead of other scope of practice or drugs and poisons work that we're doing. I'm sorry that's not a clear answer for you.

Prof. Lawler: I think I have highlighted to you previously the challenges in the prescribing landscape across the country. The TGA establishes the schedule for certain medicines. It is state and territory poisons and medicines legislation that enacts the ability to prescribe and the conditions and restrictions that apply to that. That is particularly the case for S8 drugs.

Senator STEELE-JOHN: So we've got a working group that will be working to a timeline of December to deliver back to a subsequent meeting a proposed draft. Is that the intention of the working group?

Ms Strapp: I think it would work. I am saying this before the working group has actually met. I think the hope would be to provide a framework of what the work would be that needs to happen in order to create national consistency around ADHD prescribing and treatment.

Senator STEELE-JOHN: So we don't have a timeframe yet of when we would hope these nationally consistent rules will come into effect?

Ms Strapp: Not yet.

Senator STEELE-JOHN: The communique said that there will be consultation on these new rules with relevant stakeholders. Will this include people with lived experience of ADHD themselves?

Ms Strapp: Consulting consumers on changes that affect them is a sensible idea. I would say that would likely happen, yes.

Senator STEELE-JOHN: Consulting consumers is a really sensible idea. Can you table the terms of reference for the working group? Is that possible?

Ms Strapp: When we have developed them, yes.

Senator STEELE-JOHN: Multiple states have recently, as you acknowledged, made announcements in relation to this area, either bringing them into effect or flagging an intention to increase access to diagnosis and prescription via an expanded GP pathway. To clarify, is it the position of the Commonwealth to support increased access to ADHD diagnosis and prescription via your GP?

Prof. Lawler: I can't reflect specifically on that policy question. I'm not sure if it would be helpful, Senator. I can reflect on some of the changes and some of the consultations that came of that. On the question of that, perhaps Ms Shakespeare can assist.

Ms Shakespeare: The Commonwealth supports reforms that will make sure that our health workforce is operating closer to the top of the scope of practice. We're consulting about whether or not specifically ADHD prescribing is currently supported for health practitioners, including GPs, to operate at the top of their scope of practice. I think the consultations that we have seen so far indicate that GPs could play a much greater role in access to medicines to treat ADHD.

Senator STEELE-JOHN: Has that principle, that there is a greater role to play for GPs here, been communicated by the Commonwealth to states and territories?

Ms Shakespeare: In various forums, we have discussed that this is a reform we would like to pursue collaboratively with them, including groups such as the Health Workforce Taskforce, yes.

Senator STEELE-JOHN: Can you guarantee that the national rules that are being worked on now and hopefully will be brought into effect, once developed, won't go against the state and territory decisions and intentions that have been flagged already in relation to increasing access to diagnosis and prescribing?

Ms Shakespeare: I don't think we're in a position to offer guarantees. We're working collaboratively with the states and territories with the objective of nationally harmonised approaches to make it clear and consistent for patients and providers about how they can access treatment.

Senator STEELE-JOHN: Minister, are you able today to give some assurance to the ADHD community in Australia, which is very excited about the potential of a greater role for GPs in both diagnosis and prescription, that your government is going to be backing them in their call for a greater role for GPs in this space?

Senator McCarthy: Minister Butler has worked very strongly in this area, especially since the committee report that came down in 2023. We responded in December 2024. We now see the discussions at the national level with the states and territories. So there is absolute commitment by our government, especially in this area. I give that commitment to the families out there who are wanting to see a way through this.

Senator STEELE-JOHN: We are in a period of almost constant shortage of medication when it comes to ADHD. Ritalin and Concerta are currently flagged as being in shortage. Only recently the community went through a period where Vyvanse was listed nationally as a medicine in shortage. I've heard many times from my constituents that in local areas it's still very hard to access Vyvanse medications. I'm aware that the government has approved overseas substitutes and replacements, but it's a temporary solution to what, to me, seems to be becoming a more long-term problem. My question is this: is the government taking action to ensure that there is a long-term supply of these critical medications?

Mr Henderson: Yes, we acknowledge that there has been an ongoing shortage across methylphenidate medicines. That shortage has been ongoing, particularly in relation to the modified release medicines. We have been working closely with the suppliers of those medicines. As you acknowledge, Senator, we have put in place a number of 19A approvals under our legislation for alternative overseas products. Many of those products are now also subsidised under the PBS. We also have convened a regular medicine shortages action group, which cuts across health professionals, the suppliers and other key stakeholders involved in the supply of those medicines. We continue to work closely with them. We are also working closely with the pharmaceutical wholesalers to ensure that there is a fair and equitable supply through those supply chains. I might refer to my colleague Dr Fenner to go into a bit more detail in relation to other actions we're taking.

Dr Fenner: I acknowledge that we have taken, as Mr Henderson said, a number of actions in terms of approving overseas alternatives. They are listed on the PBS. That's for the Ritalin and Concerta shortages, which are in modified release form. The immediate release forms are available. We also convene meetings with our specific methylphenidate medicine shortage action group. That includes medical colleges and health professional organisations. Through that, we can work with those organisations to support them to develop some clinical advice. We publish and communicate that on our website and publish and communicate updates to the status of the shortages as they happen because they do fluctuate. I note that you mentioned difficulties with Vyvanse. The Vyvanse shortage has resolved at a national level. Where there are shortages, we continue to work with wholesalers to ensure equitable supply. They are just some of the actions we can take. I think it's important to recognise that we can't compel sponsors to make applications either for an ARTG registered product or for an overseas alternative.

Senator STEELE-JOHN: In relation to the medicine shortage action group, I want to confirm that group has discussed the shortage of these medicines?

Dr Fenner: That's correct. We convened a specific medicine shortage action group on the methylphenidate shortages. The Vyvanse shortages have wound up.

Senator STEELE-JOHN: When did the convening of that group to discuss that issue take place?

Dr Fenner: I think the last meeting was in May. I will confirm that is correct.

CHAIR: While you're checking that, Senator Steele-John, I need to share the call. I am happy to come back to you in the next round. I will wait for the official to finish and we will share the call. Thank you.

Dr Fenner: I will take it on notice. I will be able to confirm that.

Senator STEELE-JOHN: We'll come back to this in my next lot so we can do that.

Senator BROCKMAN: Professor Lawler, I have questions on gene technology regulation. In 2021, all of the gene tech ministers agreed to a reform process going forward. Can you give me an update on where that's up to? I assume it continued?

Prof. Lawler: I am just waiting for Mr Bedford, our first assistant secretary for regulatory practice and support division, to come to the table. Gene tech policy sits there. I also note that we did have the Office of the Gene Technology Regulator on the list, but I think they were discharged earlier this week.

Senator BROCKMAN: I'm more interested in where the legislation is up to from the department's point of view, to be honest. You would have carriage of the legislation rather than the gene tech regulator?

Prof. Lawler: I'll ask Mr Bedford.

Senator BROCKMAN: Am I correct, Mr Bedford, that in 2021 there was an agreement of all the gene tech ministers to progress regulatory reform?

Mr Bedford: I believe that is correct, yes.

Senator BROCKMAN: Has that progressed? Obviously there was a change of government in there.

Mr Bedford: This has been a longstanding piece of reform that we've been undertaking. We've undertaken the first lot of public consultation and jurisdictional consultation on the policy and the initial draft bill. That has been completed. I might need to get the details from Ms Chifley in a minute. It was completed late last year. We've continued to do our further refinement of that bill, and drafting has been going on with OPC.

Senator BROCKMAN: Can you talk us through broadly what you hope that change would achieve in terms of the sector?

Mr Bedford: I might let Ms Chifley answer a few questions on the detail of the bill.

Senator BROCKMAN: To be honest, my interest in this is not so much in health, Ms Chifley. I had a long history in gene tech in the agricultural sector. I know a lot of people are very keen to continue and advance research in that area. I am keen to see if we are going to get an outcome here that actually fuels research in Australia in this area.

Ms Chifley: The reforms that will be introduced through the amendments that will implement the recommendations of the third review of the scheme will be the most significant changes to the scheme since its establishment in 2001. It will make some changes to key terminology. The main feature of the legislative reforms will be to provide a more risk proportionate approach to regulation. It will introduce the opportunity for authorisation pathways that provide for regulation that is appropriate to the risk for the organisms that are authorised through those pathways. It will continue obviously having a licensing framework. It will introduce a permits framework. It will review and reform the notification framework. That will introduce productivity benefits from having different and appropriate timelines associated with the assessments required for those authorisation pathways.

Senator BROCKMAN: Does this follow the New Zealand model, which in layperson's terms I think effectively creates a tiered structure where less dramatic changes to the genetic structure effectively require a less rigorous approach or a less technical approach to approvals?

Mr Bedford: I think—

Senator BROCKMAN: That's probably butchered language.

Mr Bedford: We have been following a bit of what New Zealand is doing. The gene technology regulator is best placed. I know that she has been following that really closely. My general understanding is that we are introducing a risk tiering model, as Ms Chifley said. The level of regulation and oversight is proportionate to the risk involved.

Senator BROCKMAN: So a relatively minor change would require a less significant approvals process than a very significant change?

Mr Bedford: That's right. Some of the reform is looking at how the assessment timeframes would be significantly less than they currently are. Hopefully, the productivity gains Ms Chifley talked about will mean that there will be more investment in gene technology in Australia because the regulatory burden has been reduced through this bill.

Senator BROCKMAN: What is the timeframe? Are you going out for another round of consultation? Is that the plan?

Mr Bedford: Of course that's the plan. There will be consultation on the bill once the next stage of drafting has been done. We are working with OPC to finalise the drafting, particularly around the risk tiering, which the sector is very interested in.

Senator BROCKMAN: You probably can't answer this. Would you expect it to hit parliament next year?

Mr Bedford: We're doing everything we can to get it introduced as quickly as possible. As you would note, it depends on the other priorities that are coming through.

Senator BROCKMAN: Excellent. That's all I needed.

Senator POLLEY: It's nice to have you in front of us again. I have some questions about the progress of the standalone hospice in Launceston. Can I get an update, please? Back in 2022, the federal government committed $20 million to work with the Tasmanian government to establish the standalone hospice in northern Tasmania. I want to get an update. There have been some delays. That was in 2022. It was due to be completed in 2026. Could you give us an update as to where we're up to? Have we even moved into the designated site yet?

Dr Develin: Good morning, Senator. The progress to date includes site selection, which is the Allambi Building in Howick Street. The building refurbishment concept design has been released and planning approval and the construction tender have been advertised. The construction, we understand, has been delayed as the parliamentary standing committee in Tasmania on public works is yet to be re-established following the state election in Tasmania. That seems to be the most recent delay. They are required to approve the contract for the Launceston hospice. We are now expecting practical completion in early 2027.

Senator POLLEY: Was the Allambi site the one that was identified by Friends of the Northern Hospice some many years ago? Has the other department of health moved out of that building? Is it in fact ready to start the renovations?

Dr Develin: I will see if my colleague has any further details. As you are aware, the Commonwealth government's role in this has really just been through the funding agreement with the Tasmanian government, which is responsible for the delivery of the project. I will see if my colleague has any further details on what has happened on the ground.

Senator POLLEY: That would be really helpful. I would like to know if they've met the milestones and what money has already been allocated. Thank you.

Ms Hermann: In terms of additional information, questions should be directed towards the Tasmanian government. I can give you some information on the money that has been provided. The federation funding agreement was executed on 9 June 2023, with $15 million paid to date of the $20 million. The final $5 million payment is due in June 2026 on acceptance of the progress report that Tasmania will provide to the Commonwealth.

Senator POLLEY: Can you confirm whether it's actually a 10-bed hospice because there is some confusion that it is 12? I'm really happy to accept 12 beds, but can you confirm whether it is 10 or 12?

Ms Hermann: I'll need to take that on notice, Senator.

Senator POLLEY: It was supposed to be December 2026. You are now saying that it will be early 2027. Is there a benchmark? Is that February? Is that June 2027?

Dr Develin: At this stage, we just have early 2027.

Senator POLLEY: Thank you very much.

Senator ANANDA-RAJAH: It's great to see closing the gap outcomes integrated into the broader program. My questions relate to the National Aboriginal and Torres Strait Islander Suicide Prevention Strategy, the 10-year plan. Could you please provide us an update on the work that the Social and Emotional Wellbeing Policy Partnership is doing on this strategy?

Mr Matthews: The strategy was finalised and released earlier this year, as you know, and released by government for that. It has obviously been a longstanding piece of work for the update of that strategy. The Social and Emotional Wellbeing Policy Partnership has contributed to the development actively of that strategy. It is something that the members of the policy partnership are remaining very actively engaged in. We have formal meetings with the policy partnership. We also have regular discussion with Gayaa Dhuwi, which is really the peak organisation and plays the key role in coordinating that policy partnership and the process for that. It is an ongoing piece of work that isn't just something that we take through for the formal meetings of that work.

We are continuing to invest in the strategy. We have an investment of about $85.3 million that we will invest in 2025-26 overall in Aboriginal and Torres Strait Islander social and emotional wellbeing for suicide prevention and mental health generally. As you know, First Nations people don't tend to separate their health from mental health, social and emotional wellbeing, and suicide. They tend to look at it very collectively from that point of view. That is, I think, what comes through the strategy. We are actively trying to pursue that as the government and work with the policy partnership around it to make it work fairly effectively. That is everything from the work that the department does to build the broader Aboriginal community controlled health sector and grow the ACCHO sector in particular and through the investments we make, particularly in mental health, where we've continued programs like the Culture Care Connect activity. It has been funded for a further period of time. It is

about $20 million a year. It particularly works for aftercare. A lot of that goes into the ACCHO sector and other providers. Of course, we continue to fund initiatives such as 13YARN et cetera that provide services for people.

Senator ANANDA-RAJAH: What was that last one?

Mr Matthews: 13YARN. It is the crisis line specifically set up for Aboriginal and Torres Strait Islander people similar to Lifeline but run specifically for Aboriginal and Torres Strait Islander people. It works in complement with the investment that comes through the National Indigenous Australians Agency for social and emotional wellbeing. There's a body of work there. We're really trying to get the policy partnership's advice about how we progressively bring that in and integrate it more over time. Of course, there's the work that the Productivity Commission has been doing reviewing the National Mental Health and Suicide Prevention Agreement. It specifically calls out that there is some further work needed, specifically for Aboriginal and Torres Strait Islander mental health. It will also give us a few things. There are a range of things we have been doing. The policy partnership has been guiding through the strategy the activities that we're doing now and then work that will be done through the renegotiation of that national agreement.

Senator ANANDA-RAJAH: Do you have a close working relationship with the policy partnership?

Mr Matthews: Yes.

Senator ANANDA-RAJAH: You're in constant conversation?

Mr Matthews: There wouldn't be a week that goes by that we don't have some engagement with Gayaa Dhuwi in particular. We also work very closely with NACCHO, as the peak body for the Aboriginal community controlled health sector, which is obviously a very significant part of that landscape as well, and a range of other organisations.

Senator ANANDA-RAJAH: Are there new elements being drawn up as part of this $85 million, or is it funding of ongoing programs?

Mr Matthews: There are ongoing programs. Like most ongoing programs, you're also looking at what you can do within those programs to improve them over time. We try not to do them as a set-and-forget program as well. There are a range of things in there. Governments have probably put health in one basket and mental health in another and then suicide in another. How we collectively bring that together a bit more effectively over time, I think, is the question that the policy partnership is asking us to think through. But that is a complicated piece of work, because obviously it's not only for the Commonwealth but also for the states and territories to do that collectively. It would be an active area under the renegotiation of the national agreement.

Senator ANANDA-RAJAH: The government invested $9.2 million—forgive me if I get this wrong—in the Kadadjiny Centre in parallel with launching the strategy. Can you just go through how this investment will help with driving down the suicide rate?

Mr Matthews: I think we can. I will refer to my colleague Ms Price to provide detail on that.

Ms Price: The Kadadjiny Centre is an expansion of the current Centre of Best Practice in Aboriginal and Torres Strait Islander Suicide Prevention led at the University of Western Australia by Professor Pat Dudgeon. They support a range of projects that contribute to Aboriginal and Torres Strait Islander suicide prevention. The additional investment that you are talking about expands the investment for that and merges in some other Aboriginal and Torres Strait Islander led suicide prevention initiatives into one large centre. Kadadjiny is the working name for that centre. I imagine there might be some change to that upcoming as well.

Senator ANANDA-RAJAH: When you say 'best practice', what does their best practice look like that others can learn from? What are the core elements?

Ms Price: I don't have them off the top of my head, Senator. I can get that for you on notice. I think the core components include culturally led programs that are place based and community focused.

Senator ANANDA-RAJAH: With respect to the workforce, how are we growing the First Nations workforce?

Mr Matthews: There are a range of things. Obviously, we have a range of workforce programs already underway. In a previously funded initiative, there were some positions. For example, there were psychology placements and university placements and 500 trainee placements. There was priority given for them to access priority groups. Of course, First Nations is one of them. That is an example where we do have workforce programs generally for each of them. There's an element that is targeted towards the First Nations workforce for mental health. It applies to other disciplines as well. There are programs such as the Puggy Hunter scholarship scheme that run generally as well. I note that there are a range of additional psychology positions funded through

the National Indigenous Australians Agency as well. It doesn't come through the health portfolio but will contribute to the overall health workforce. It is coming through there.

Senator ANANDA-RAJAH: How many trainees or how many students are currently enrolled? Do you know?

Mr Matthews: From the specific point of First Nations, I would have to take that on notice and provide it. I don't have the detail with me today on how many of those specifically we have for First Nations across those initiatives. It would be a reasonable number. I would need to take it away and add it up across all of the programs.

Senator McCarthy: I can say that, for the Aboriginal health practitioners in terms of the 500 traineeships across Australia, we've certainly got over 400 in place.

Senator ANANDA-RAJAH: Fantastic.

Mr Matthews: There are some that are specific to mental health that we probably run and then there are ones across the broader health workforce as well.

Senator ANANDA-RAJAH: Can you explain for the benefit of the committee why it's important to have culturally appropriate care, particularly for First Nations communities?

Mr Matthews: Well, from a mental health point of view and, I guess, a general point of view, which is consistent with every other aspect of First Nations health, across social policy generally there is clear evidence that service adherence and uptake by Aboriginal and Torres Strait Islander people is more effective, more likely to happen and more likely to be continued when you have higher proportions of Aboriginal and Torres Strait Islander workers in those services. Obviously, from a cultural understanding point of view, for people who are non-Aboriginal or First Nations, you can learn lots. Obviously, for people who are First Nations, their absolute understanding of that is so much richer than anybody else's can be. Having that workforce there makes people feel far more comfortable and understood. They understand the perspectives and the culture where they are coming from and are more able to tailor messaging and care to people in that context.

Senator ANANDA-RAJAH: I imagine that trust is important. Professor Kidd, do you have anything to add?

Prof. Kidd: Trust is very important. Increasing the number of First Nations health professionals is absolutely important for Australia, for not only people working in their own communities but also the influence that people have right across the health care sector.

Senator ANANDA-RAJAH: Absolutely. Thank you. This is my last question. Can you talk us through how we train up that workforce? Are there training centres that provide the specialist training?

Ms Strapp: As Mr Matthews talked about, we fund a range of organisations that are tasked with boosting the First Nations health workforce. That includes health practitioners and health workers, medical doctors, nurses and midwives and allied health workers. They run a range of programs. They also provide holistic support to those health workers and the health professionals. They work closely with universities, TAFE organisations and VET organisations around the support that is delivered. In many cases, it's with Aboriginal community controlled RTOs that run culturally appropriate services. They work very closely with universities and TAFEs across the country to ensure that their training and support is culturally appropriate and that we can, I guess, attract and retain a really high-quality First Nations workforce. I will say that we've had a really good increase in the number of health workers registered with Ahpra over the last few years. I think we've reached—

Ms Bekis: We have seen significant growth in our Aboriginal and Torres Strait Islander workforce. We have seen a 50 per cent growth over a number of years. We can provide those numbers on notice. In terms of the traineeship program that you referenced before, just to give you those numbers as well, the target was 500. We have 551 trainees who are registered. We have 152 who have completed the training, and 289 are currently in the training program. What we are also seeing is really strong employment outcomes. Eighty-five per cent of the cohort is employed in Aboriginal community controlled health organisations. Eleven per cent are working within our mainstream health services under government, such as hospitals funded by government and the like. We are tracking this program very closely. We are working together with NACCHO, which is delivering this program in partnership with Aboriginal community controlled RTOs across the country.

Senator ANANDA-RAJAH: That is fantastic to hear. What a good problem to have. Thank you.

Senator BRAGG: I have lots of questions for Ahpra.

CHAIR: Senator Bragg, Senator Liddle wanted 10 minutes quickly. If we can go there first, we can come back to you, if that's okay.

Senator BRAGG: Yes.

CHAIR: Senator Liddle, you have the call.

Senator LIDDLE: Thank you. This question relates to the financial management and work that is done on due diligence in relation to Aboriginal community controlled health services. Can somebody talk to me about that, please?

Mr Comley: Chair, we have Ahpra here now.

Senator BRAGG: I'm in the hands of the chair.

Australian Health Practitioner Regulation Agency

[10:21]

CHAIR: If Senator Liddle is happy to hand the call back, we'll go to Ahpra with Senator Bragg.

Senator BRAGG: Your role is to maintain standards in the Australian medical profession. Is that right?

Mr Untersteiner: We certainly play a key role in setting standards for health practitioners, yes.

Senator BRAGG: Part of that is ensuring that patients feel that they are safe in the hands of Australian medical practitioners. Is that right?

Mr Untersteiner: Absolutely. It's paramount within our legislation.

Senator BRAGG: You would know that we are living through a period where extreme antisemitic material is being circulated around our country. Jewish Australians often feel that they are being targeted, including sometimes inside your profession. How many complaints have you had in relation to medical professionals engaging in antisemitism?

Mr Untersteiner: Sure. You're right; this is a very serious issue that we are taking very seriously, Senator Bragg. From the outset I want to call out, as the CEO of the health practitioners regulator, that we have no tolerance for discrimination in the health system. We are against any form of discrimination. In relation to the conflict in Gaza that we are seeing at the moment, we have received 188 notifications since October 2023 that relate to 95 different practitioners.

Senator BRAGG: Ninety-five?

Mr Untersteiner: Yes.

Senator BRAGG: You also have a role in registering nurses, don't you?

Mr Untersteiner: Correct.

Senator BRAGG: I have to say that one of the most outrageous things I've ever come across in my time in parliament was the statements from the nurses in the New South Wales system that they would kill Jewish patients, that they wouldn't treat Jewish patients and that they would like to send them to hell. What happened to those nurses?

Mr Untersteiner: I can probably help give you a bit of context about the national scheme and how it works. I will keep it brief. We currently work in a federated system. The power that Ahpra has comes off the back of state and territory legislation. There are some differences in that legislation. One of the differences is most evident in New South Wales. What that means is that, although we are the national regulator and we register practitioners nationally, it is actually the Health Care Complaints Commission in New South Wales that has the legislative jurisdiction to manage complaints around practitioners within New South Wales.

Senator BRAGG: Nurses or doctors?

Mr Untersteiner: Both.

Senator BRAGG: What about other states in terms of, let's say, doctors? In other states you do have—

Mr Untersteiner: We do, absolutely.

Senator BRAGG: So you can deregister or you can give sanctions?

Mr Untersteiner: Absolutely, yes.

Senator BRAGG: I want to ask you about a particular matter concerning Dr Omar Azzam. Are you aware of this case?

Mr Untersteiner: We're aware of the matter you're talking about, yes.

Senator BRAGG: The allegation here quite clearly is that this doctor has put red triangles over IDF soldiers and has said that Zionists are Zionist Nazis. These appear to be extraordinary, disgusting statements to have come from a medical practitioner. What has happened in this case?

Mr Untersteiner: Under our legislation, we are bound by the confidentiality of practitioners. Unless the matter becomes public through a tribunal hearing publishing, I'm unable to talk specifically about any ongoing or closed matter. Again, I might step back and flag that we do take this very seriously. Put aside this case. We take these kinds of allegations exceptionally seriously. Within the organisation, we have a dedicated unit that is looking at these matters. We look to expedite those matters to make sure they are taken seriously. We have special training of our employees to make sure that they are ready to handle those sorts of matters. Where we need to, we make referrals through to the tribunal for action. Again, we have zero tolerance for discrimination in the system.

Senator BRAGG: You say that you've had 95?

Mr Untersteiner: Correct.

Senator BRAGG: That would be one of them?

Mr Untersteiner: Again, I can't talk about a particular matter, Senator Bragg. It's not that I don't want to be helpful. We have very particular confidentiality obligations.

Senator BRAGG: If you have had 95 of these, that would indicate to me that it's a potentially systemic issue. Jewish people could be going to get a procedure done by someone threatening to kill people. That's not the Australian standard. Australians would expect better than that. What assurance can you give this committee in relation to these 95 complaints? Let's assume that they are all valid or mostly valid. Why would people want to raise complaints that aren't valid? People would raise them if they were fearful. What confidence can you give that the Australian medical system is a safe place for Jewish patients?

Mr Untersteiner: Sure. I'm happy to answer this question, Senator Bragg. What I can tell you is that, of those 95, about half of them relate to some form of complaint about antisemitism. About half of them relate to complaints about Islamophobia. We're talking about half and half. When we look at the make-up of those matters, many of the notifications, as we refer to them, relate to some kind of social media activity. Of those, many of those do relate to a complaint where someone has reposted some kind of news article, for instance. It could be an ABC article or something like that. Many of them fit within that. In many of those cases, we wouldn't see it as a case where we need to take particular action. However, of course, there have been more serious matters. I won't pretend that there haven't been.

Senator BRAGG: How many doctors have been rubbed out?

Mr Untersteiner: First of all, I need to flag that we don't have the power to remove registration. We have the power to refer to a tribunal. We currently have two cases awaiting a tribunal.

Senator BRAGG: Two?

Mr Untersteiner: Yes.

Senator BRAGG: In relation to antisemitism?

Mr Untersteiner: I will hand to Jamie Orchard, general counsel, to answer that question.

Dr Orchard: They relate to the nature of the complaints that Mr Untersteiner was referring to—namely, social media posts. They might relate to antisemitism. They might relate to Islamophobia type posts.

Senator BRAGG: So two are before the tribunal?

Dr Orchard: Correct.

Senator BRAGG: What are the sanctions?

Dr Orchard: Tribunals have a range of powers once they consider the matter. If they were to determine that the conduct in making those posts amounts to professional misconduct, they are able to impose a range of sanctions ranging from the cancellation of registration to disqualification for a period, suspension and so on.

Senator BRAGG: My understanding in relation to this matter is that there is an ongoing issue here. Frankly, as I say, if I were a Jewish patient, I would be very worried about the kind of treatment I would be receiving from persons who are effectively threatening the community by wishing death upon people. Doctors have a special role in our society. Posting a news article is not the same as wishing death on people. It's a different thing. In this case, I understand that you can't refer to it in detail in this committee. My understanding is that you've closed that case. What I would seek from, maybe, the chair is whether it's possible for this committee to seek some sort of private briefing on how in fact these sensitive matters are being progressed. The parliament here in Canberra would expect that we set up a system for all Australians to get safe medical treatment.

Mr Untersteiner: Senator Bragg, I can share with you that I have confidence that's what they're getting. I share your concerns about discrimination in the health system. Again, I say that we have no tolerance for it. We

are taking absolute action where we need to. Again, it can be very difficult. I can't talk about these cases because in many of these cases there are always further facts that I'm sure you and others might not be across as well, which is important to understand. I'm sure you do understand that, Senator Bragg. Again, I can give complete confidence that we've got no tolerance for discrimination. I feel confident that any Australian is able to go and get safe health care and not worry about discrimination because we're dealing with it.

Senator McCarthy: Chair, before you conclude with Senator Bragg, can I also say, for the benefit of the committee, that on 12 September 2025, health ministers met and issued a policy direction to the Australian Health Practitioner Regulation Agency, Ahpra, and our national boards to improve the health practitioner response to racism and discrimination, including antisemitism. The policy direction asks them to ensure that health practitioners undertake education and training to help promote a culture of anti-racism in health care and to undertake a review of the current complaints process on racism and discrimination, including anti-Semitism.

Senator BRAGG: I have one final question.

CHAIR: I want to make a comment. I am very happy to take up the issue of organising a private briefing with Ahpra at your request by your colleagues, as the voting members of this committee, to ensure that we have some of those questions answered. A final question?

Senator BRAGG: Thank you, Chair. You've covered it off. Effectively, I think it would be important for us to have a private briefing so that we can be absolutely confident that these issues are being properly progressed and taken seriously by Ahpra. Our role as the Senate is to ensure that all the agencies are doing what they can to protect the community. I understand that you can't canvass everything necessarily in this domain. I'm grateful for the chair's offer of a private briefing.

CHAIR: There are five or so minutes, Senator Liddle, if you want us to return to you.

Senator LIDDLE: We often hear in this area that due diligence is done. I want to ask you about the financial statements of Yadu Health Aboriginal Corporation, which you fund, and their 2023-24 annual report. You know that there have been some governance issues at Yadu which delayed significantly the building of a clinic in that area. Most concerning is the period post the removal of the cashless debit card and the significant increased issues in that area. Yadu's financial statement refers to $554,000 paid to other related parties. The other related parties are defined in the annual report as close family members of, and entities controlled by, key management personnel. When you did your due diligence at handing over millions of dollars, did you actually look at stuff like that and ask questions?

Ms Turner: I would have to take that question on notice. It would have depended when the annual report was actually completed and whether we had time to look at it. I'm not quite sure that I can answer that question for you right now. I will take that on notice.

Senator LIDDLE: Okay. This is not particular to Yadu. There are a number of annual reports you can look at where this issue occurs. Their annual reports an underspend of some $220,000 for their organisation, which obviously means that some aspects of their service were not delivered. Do you look at those kinds of things and actually ask the question, 'Who missed out because this organisation couldn't get its act together on delivering on what it said it could deliver when you gave it the funding?'

Mr Barratt: We do consider underspends. Many ACCHOs do have underspends. That primarily relates to things such as an inability to retain workforce or for infrastructure projects that might include delays in being able to get the correct accreditation or weather related delays. We don't necessarily look at an underspend as a failure to deliver services.

Senator LIDDLE: I put it to you that when there is an underspend—I have had complaints about this—the practice is that those organisations retain the money whereas there are other providers that could do the work. People miss out because of the inability to put the money with the organisations that can actually do the work when it's required. How do you respond to that?

Mr Barratt: In the particular case of Yadu, I'm not sure there is another organisation in that area that would be able to pick up that slack or that has the capacity or the workforce necessary to deliver those services.

Senator LIDDLE: Do your agreements allow for that, because it's not just a problem at Yadu?

Ms Turner: That's what I was about to say. Our agreements don't actually allow for that. We would not be able to move funding between organisations as such. It basically would be looked at on a case-by-case situation. There is not that ability to move between grant agreements. If funding is committed to, for example, an infrastructure project, it is for that project. Unfortunately, it is not able to be moved to another project.

Senator LIDDLE: We see this for medical programs. It's not just infrastructure.

Ms Turner: Yes.

Senator LIDDLE: Let's be clear on that. The government committed to reducing public sector consultants. In that same annual report, Yadu said that it spent $1 million on consultancy fees in that year. Is it acceptable that consultants are outsourced by these taxpayer funded bodies? It's a significant amount of consultancy fees.

Ms Turner: Is it in relation to the actual infrastructure project itself? I want to clarify.

Senator LIDDLE: One would assume that, considering that build is two years behind, it probably would have not been $1 million for that.

Ms Street: I don't think it's unusual for organisations to bring in those services and that specific expertise. When it's about infrastructure, we wouldn't necessarily expect the organisation to have all of that expertise at hand and that they would be outsourcing some of those components. I would say that wouldn't be that unusual. If it were delivering the specific services for which they've been granted, that might be a different question. I think for something like an infrastructure project or for an evaluation, that wouldn't be unusual.

Senator LIDDLE: What you are saying is that $1 million wouldn't trigger you to go, 'What's actually going on there? Should we put even more money into that organisation?', which you have done?

Mr Barratt: I think with organisations in particular that have infrastructure projects, we advise that they contract a construction project manager.

Senator LIDDLE: Let's not keep talking about infrastructure because this is not about infrastructure alone, please.

Mr Barratt: I think with some of the organisations we also encourage or support organisations to seek consultancy services for things such as business management services or business improvement management services. Nurse advisers, I think, are currently employed by Yadu to help them improve their practices. There's a wide range of reasons why they might consult.

Senator LIDDLE: I will move to another topic. I am assuming that you are the same people who can help me with this.

CHAIR: Senator Liddle, I do need to share the call. I'm happy to come back to you. I will need to go to Senator Steele-John and a few others before we hit the break. But we will get back to you.

Senator LIDDLE: Thank you.

Senator STEELE-JOHN: Minister, through the national standardisation process for diagnosis and prescription for ADHD care, can you guarantee and assure people that no-one will end up worse off? That is, if you live right now in a state or territory that is currently in the process of opening up pathways to ADHD care via your GP, which basically is much less costly, as a result of the national standardisation process, nobody will have those access pathways shut off?

Senator McCarthy: As I said previously, Minister Butler has been very committed to wanting to move on the recommendations with regard to the report that came through on ADHD. He has done that through recommendation 5, which is coordinating with the states and territories in terms of the recent health ministers meeting in September. I can say to families across Australia that there is a committed minister here followed by his department to work on that. It also includes the uniform reforms enabling GP diagnosis and prescription of ADHD medication. It should be designed to ease pressure on individuals, families and carers without a doubt and who currently navigate through a really costly and overloaded specialist system. So there is a real commitment by Minister Butler to do the work in terms of the recommendations that have come through.

Senator STEELE-JOHN: I want to be really clear for people that you and your government will ensure that people won't go backwards in relation to access to ADHD care that they might be able to access in their state or territory.

Senator McCarthy: I would certainly say to all Australians that our government is focused on wanting to improve health and the cost of living in terms of health with cheaper medicines and with what we've done with Medicare. Certainly for the families that you are representing, Senator Steele-John, we and the minister are very aware of the need to be able to move in this space. I cannot say any more than what I've said to you already on the matter.

Senator STEELE-JOHN: Let's go back to the meetings of the medicine shortage action group.

Dr Fenner: I can confirm that the meeting of the medicines shortages action group was on 13 May. Since that time, we've communicated with them regularly via email. We've done so providing updates, particularly when

new 19A overseas alternatives become available or are PBS listed. We've communicated with them through May, June, July and, most recently, September.

Senator STEELE-JOHN: When is the next meeting of the action group?

Dr Fenner: I don't think we have one scheduled at the moment. We have been communicating, as I said, through email updates. If there's a big shift in supply, that would prompt us to reconvene that group, yes.

Senator STEELE-JOHN: Is the government looking at new ways to encourage onshore manufacturing of these medications so that we can have more long-term confidence in availability?

Ms Shakespeare: I think the department of industry has a range of programs to support local manufacturing of different products and has a focus on medical therapies. We're probably not in a position to talk to you about them. We do have a range of approaches in the health department to try to manage shortages beyond the work that Dr Fenner has been discussing. We had a pharmaceutical wholesaler agreement reached at the end of last year. It included additional funding for wholesalers to make sure we're managing shortages of PBS medicines in a more coordinated way. Millions of dollars in funding under the community services obligation arrangements for wholesalers of medicines are to support the Commonwealth in managing shortages, to proactively manage the supply of PBS listed medicines into regional, rural and remote areas, and triaging orders of PBS medicines to make sure that we are supporting the national medicines policy. We also have the onshore stockpiling arrangements under the PBS, which applies to certain medicines. We have, as discussed earlier, arrangements for the PBAC to urgently consider overseas brands listed by the TGA in section 19A listings. We've got a range of approaches to manage shortages across the medicine supply chain.

Prof. Lawler: I will also highlight—I will ask Mr Henderson to comment on this as well—that we recognise there is a perception that we are simply reactive to shortages. There is a challenge in that. We have a number of mechanisms for identifying shortages. They are active. I might ask Mr Henderson to speak on the stakeholder forum that we have assembled and are using to approach it in a more systematic way.

Mr Henderson: We have set up what we are calling the medicine shortages stakeholder forum. That is represented by over 40 groups across health professionals, consumer groups and industry. We had the first meeting on 3 September 2025. We are going to utilise that forum in an ongoing way to test potential reform options. That particularly relates to reform options that the TGA can implement to mitigate the impacts of medicine shortages. It is also a key forum where we can receive signals and information back through those key stakeholders. They can share not only their ideas and views but also the impact that shortages are having on their representatives.

Senator STEELE-JOHN: Could you table for us the membership of that forum and the next meeting date for that forum? That would be most appreciated.

Mr Henderson: Certainly.

Senator STEELE-JOHN: One of the challenges that I'm hearing about really clearly from the community is that overseas registered replacements under 19A are often inaccessible to many people, particularly those not currently PBS listed. Basically, that causes a significant financial barrier for people to practically afford the medication, even if it is technically available. Often you rock up to your pharmacy and they don't even have it in stock. My question to you is this: are overseas registered replacements eligible for listing on the PBS?

Ms Shakespeare: Yes. For many medicines that go into shortage, we use PBS listings of 19A alternatives as an effective way of managing our way out of that shortage. Last year, we had an example of emtricitabine and tenofovir, where we were able to make 19A listings. Recently, Bicillin had a 19A listing so that we've got greater access to that medicine in shortage. Many of them do get PBS listed.

Senator STEELE-JOHN: In relation to the shortage of ADHD medications, how many substances have we got under 19A at the moment that have been approved and that are on that list as an overseas replacement?

Dr Fenner: We have several 19As with PBS listing. Supply can fluctuate a bit. It depends. As I said, supply can fluctuate. We keep them up to date on the website because of that fluctuating supply.

Senator STEELE-JOHN: How many of them are approved under 19A that are not PBS listed?

Dr Fenner: I don't have that in front of me, but I can come back with that.

Senator STEELE-JOHN: If you could. Have the sponsors of any of the currently 19A listed replacements made an application for PBS listing?

Mr McIntyre: My division handles the listing of items on the PBS. I would need to take on notice the current status of applications for listing these drugs on the PBS. We deal with these in an expedited manner. We encourage sponsors to bring them forward. We work actively with sponsors that suggest they may be able to get a

supply of suitable substitute medications. It's fair to say that in some cases sponsors aren't able to procure a sufficient quantity so that they are confident they can provide that supply. But we work with them to try to manage that dynamically. We also work with the pharmaceutical wholesalers who distribute these medications to pharmacies to seek to ensure that there is as equitable access as possible in cases where supply is limited.

Ms Shakespeare: A particular example that we can provide, Senator, is a 19A approved product of methylphenidate hydrochloride tablets. A Swiss brand was recommended at the May 2025 PBAC and has now been listed on the PBS. So we do have some 19A brands listed.

Senator STEELE-JOHN: Just to be clear, that's the section 19A replacement for Concerta. It's sponsored by Medsurge Healthcare. Is that the substance you're referring to there?

Ms Shakespeare: It's a Switzerland version of Concerta.

Senator STEELE-JOHN: My understanding is that was not PBS listed. I have had reports of people facing costs of up to $200 per 30 tablets. So you say it is?

Ms Shakespeare: My advice is that we've listed it on the PBS, yes.

Mr McIntyre: Yes, I can confirm that it has been listed on the PBS under 19A.

Senator STEELE-JOHN: When was it listed?

Mr McIntyre: It was listed on 1 July 2025 for provision under the PBS until 31 January 2026 at this stage.

Senator STEELE-JOHN: Okay. The TGA's website shows the relevant medicine shortage pages around these substances indicates that the government expects the shortages of ADHD medications to last through until 2026. Mid-2026, I think, is the wording used. Are you telling me that the PBS listing will expire in January 2026?

Mr McIntyre: The way the 19A applications work is that, at the time the application is made, there's a sunset date. There are provisions that allow them to be extended. As we draw closer to that date, there will be an assessment as to whether there's a need for an ongoing section 19A application. We will work with the sponsor, if they are willing to do so. We will then ensure that there are arrangements in place to allow that to be considered. As I'm sure you are aware, Senator, there is ongoing tight supply for a range of reasons to do with these medications. There are issues associated with the country of origin and the APIs that underpin them and the restrictions of these drugs, which can be misused, of course. That means that global supplies of these drugs are subject to regulations in other countries that mean it's challenging for the sponsors to bring them to Australia. But we continue to work on those supply chains to ensure that we can get as much of the globally available supply as possible.

Senator STEELE-JOHN: This is my last question and then I will share the call. Can you provide on notice the list of currently 19A approved overseas replacements that are not PBS listed currently and whether their sponsors have in fact made an application for listing on the PBS and the status of that application, if it has been made?

Mr Henderson: Yes, we can, Senator. I might add that we also strongly encourage, when we go out for the 19A, that they pursue that PBS listing as well. That's part of our processes.

Senator STEELE-JOHN: Thanks very much.

CHAIR: Thank you for your diligence, Senator Steele-John.

Senator HANSON: I have questions on gender dysphoria. For some context, I will ask about the advice the minister requested from the National Health and Medical Research Council with regard to gender dysphoria that was released under freedom of information provisions. It was 2024-25 document 009.4. Is it still the case there's no medical research council approved guidelines on gender dysphoria for use in Australia?

Dr Develin: There are no National Health and Medical Research Council guidelines; that's correct, Senator Hanson. At the moment, there are no National Health and Medical Research Council guidelines. However, clinicians are working under other national guidelines that have been developed through professional groups. The minister has asked the NHMRC to undertake a national process, which is a very rigorous and evidence based process. There are clinicians working under guidelines that have been developed by their own professional bodies.

Senator HANSON: So anyone in Australia prescribing puberty blockers, hormones or surgeries for gender dysphoria cannot be possibly doing it under your guidelines?

Dr Develin: As I said, there are no national guidelines. There are, however, professional bodies that have released these guidelines. All of these services that are operating under the states and territories will have their

own clinical governance models. All the professionals need to meet their own requirement standards for the health professional that they are.

Senator HANSON: If these people are actually prescribing puberty blockers and hormone treatment and they are not under the health professionals guidelines and if these are actually doing damage to the children, who is going to be held responsible?

Dr Develin: With regard to puberty blockers, it is actually reasonably rare for them to be prescribed. It is not common. Does it happen? Yes, but it is not common. Quite often these children are seen in multidisciplinary services. Puberty blockers are only one form of care that those children and their families may work with their professionals on. The professionals prescribing them are working under their own clinical requirements as a health professional.

Senator HANSON: I tend to disagree with you. I am getting a lot of complaints from parents who have actually lost control over their children because they are going to see clinicians and they've given the right to it. The parents can't interfere. No-one can actually advise them differently. They've lost control over their children. Children as young as 15 years are actually being told that they've got gender dysphoria. As young as 15 years, they are having their breasts removed or their penises removed because of this gender dysphoria. They are telling the kids: 'No, you've got a problem. Look at what sex you are. Therefore, you must have gender dysphoria.' Parents are saying that they are losing control of their kids. There is one case here. I want to know what the health department has. This is from one parent. A three-year-old child was the subject of a PhD research project published in 2025. It named the child as transgender at three years of age. They socially transitioned the child in a Victorian pre-school classroom. How the hell is that happening?

Dr Develin: I'm not aware of the circumstance that you are referring to. We wouldn't comment on that. What has happened in Victoria is not something that is in the remit of the department of health.

Senator HANSON: The department of health should be looking at the wellbeing of the children. I feel that it's just not being looked at at all. You don't have guidelines for this. You have clinicians giving puberty blockers. Is it true also that your puberty blockers are off label use? They are not TGA approved for gender dysphoria. Is that correct?

Dr Develin: My understanding is that there are reasons for the common medications used for puberty blockers to be approved by the TGA. There are certain types of cancer or early onset puberty and those sorts of things. They are privately prescribed if it is for the purpose that you are discussing.

Mr Comley: I suggest that we get the TGA to the table. The Chief Medical Officer may want to comment. I want to reiterate what Dr Develin said, which is that there are not national guidelines at the moment. That is why Minister Butler referred it to the NHMRC. But there are local guidelines that are being used by clinicians.

Senator HANSON: But it has asked for a review because there are concerns about it. That review is not going to go ahead until about 2027. Is that correct?

Mr Comley: Well, the minister has asked for a review to look into whether national guidelines would be appropriate, noting that there are local guidelines in each state and territory that clinicians are operating under. I think if you have a question about the TGA, I would like to throw to Professor Lawler. Perhaps the Chief Medical Officer might then like to comment.

Prof. Lawler: I will ask Dr Dascombe to give us some clarity around the approvals and the specific indications for the medicines that we have entered on to our register.

Dr Dascombe: As you alluded to, Senator, there are five types of medicines that are called gonadotropin releasing hormone analogues, or what you referred to as puberty blocking medications. There are five types registered for use in Australia. Of these, only two single active ingredient products—leuprorelin acetate and triptorelin embonate—are registered for use in children. The only TGA approved and registered indication for these medications is for the treatment of central precocious puberty. The use of these medications in gender affirming care is done off label. This is a common and legal practice in Australia.

Senator HANSON: What age can these puberty blockers be given to a child?

Dr Dascombe: It's at the discretion of the treating clinician in consultation with-—

Senator HANSON: There's no age limit to it?

Dr Dascombe: the patient and their carers.

Prof. Lawler: As mentioned by Dr Dascombe, the indicator treatment for which it's entered into the register of therapeutic goods is for central precocious puberty. That's a hormonal conditional at which puberty kicks in too early. It's the treatment of a medical condition. When it comes to use off label, that is a clinical practice decision

that is not regulated by the TGA. It is undertaken in line with clinical health practitioner practice, various codes of practice and local guidelines.

Senator HANSON: Do you investigate these psychologists about their qualifications? With some of these, I hear that they've only just interviewed the child for about 20 minutes or half an hour and are prescribing drugs to them. Where is the oversight of this?

Prof. Lawler: It's not the role of the TGA to regulate clinical practice or practitioners.

Senator HANSON: I'll go back to the health department. Who can answer that question for me? Who oversees this? Understand where I'm coming from. Parents are telling me they've got concerns. They are taking their children to see these clinicians-—these psychologists or whatever. Within 20 minutes or half an hour, they are actually prescribing. They can't stop them. If the parents intervene, they are questioned over their care of the rights of the child.

CHAIR: Senator Hanson, can we let the officials answer the question.

Senator HANSON: Yes, I know.

CHAIR: Sorry to interrupt you.

Senator HANSON: But they need to have the full understanding of my questions.

CHAIR: I agree. Perhaps if we can cut to the questions and the content, we can get the officials to give you some answers.

Mr Comley: Thank you for the question. I will get Trish Clancy to answer and see if the CMO wants to comment. I also note that, in terms of the regulation of professionals, Ahpra would be the body for that.

Ms Clancy: Decisions regarding clinical care for minors are shared between the clinician, the young person and their family. If there's a disagreement on the diagnosis, as you suggest in some of the cases you've heard of, the treatment or the capacity of the minor to provide informed consent, the Family Court has ruled that this requires an application to the court to resolve the dispute consistent with the child's best interest.

Senator HANSON: So the parents have to go through the court system?

Ms Clancy: If there is a disagreement on the diagnosis, treatment or care of the child.

Senator HANSON: That review is going to go ahead. Is that right? This is your three-year review of $1.5 million. Is that correct?

Mr Comley: Professor Wesselingh may want to comment.

Prof. Wesselingh: Yes, we have been asked to write NHMRC guidelines. That process has started. The committee has been appointed. The committee will start to meet. That process will take three years, but we have been asked to provide interim commentary on the use of puberty blockers in the middle of next year.

Senator HANSON: Thank you. Does your review cover the fact that Justice Strum, in his Devin judgement, had also questioned the Australian standards of care and treatment guidelines for trans and gender diverse children and adolescents? He found that Professor Telfer did not recognise that children may not be capable of making life altering medical decisions about their gender identity.

Prof. Wesselingh: The committee will look at all the guidelines, both Australian and international. I should emphasise that there are no NHMRC endorsed guidelines at the moment. We will be looking at all guidelines. We will be looking at all commentary. It will be considered by the committee, absolutely.

Senator HANSON: There has been a lot of controversy and there have been discussions on the floor of parliament about whether puberty blockers are reversible or irreversible. Can you answer that question? Are they irreversible?

Prof. Wesselingh: Again, the committee will be looking at that. We have members on the committee who are experts in that area.

Senator HANSON: I'm not asking about the review. I'm asking now. In your expert opinion, are puberty blockers irreversible?

Prof. Wesselingh: I'm not an expert in that area.

Senator HANSON: Is there someone here who is who can answer that question?

Prof. Wesselingh: Well, there are members on that committee who will be looking at the evidence.

Senator HANSON: I'm asking whether there is anyone here who can answer that question now.

CHAIR: Senator Hanson, I think the official is going to provide the answer to you. We can wait until Professor Wesselingh can provide the answer to you.

Prof. Wesselingh: The way the NHMRC works with its guidelines is that these are evidence based guidelines. We look at the evidence very carefully before making determinations. At the moment, I can't answer that question because the evidence has neither been collected nor looked at very carefully to make that determination.

Senator HANSON: So, at the moment, you're allowing puberty blockers to be given to children when you can't determine whether they are irreversible or not irreversible. Don't you believe that it's a failure of our health department to allow these drugs to be given to children who may be going through a phase and really are being led down the path that they are in the wrong body?

Prof. Wesselingh: At the moment, we are developing guidelines. The oversight of the prescription of puberty blockers doesn't sit with the NHMRC. I can't really answer that question. I think that question has been answered. Maybe Professor Lawler would like to answer that question further.

Prof. Lawler: I will just reiterate that there are a number of elements within the regulatory space here. The Therapeutic Goods Administration, as the regulator of therapeutic goods, has assessed a number of these gonadotropin-releasing hormone analogues, as Dr Dascombe has highlighted. The only ones that are currently indicated and entered into the register by the TGA for treatment in children are for central precocious puberty. The regulation of health practitioner practice, including off labelling prescribing, sits with Ahpra and local clinical governance mechanisms.

Senator HANSON: Can you answer me? Are they irreversible?

CHAIR: Senator Hanson, I need to check how long you need. I need to share the call before we head to the morning tea break with Senator Antic. This is your last question and you can wrap up.

Senator HANSON: What would be your recommendation to the health department if there are no guidelines? You can't answer whether these are irreversible. Would it be in the best interests of children that these not be given to them at the moment until we have a clear indication whether they are reversible or irreversible? A parent came to see me. Their child went through this and thought they were in the wrong body as a female. They took hormone treatment. They are now locked in the room three months at a time and will not come out. They lost the hair on their head and are growing a beard. They have hair on their chest and hate the way they look. They are sorry they made the decision to take this. Is it in the best interests of the people of Australia and their children to put a block on these hormone treatments until you can give a clear indication whether they are irreversible before destroying any further children's lives? Do you think that's common sense?

CHAIR: Can we get a response from Mr Comley?

Mr Comley: I'm not sure we can add anything more. The procedures are there to the extent they exist. Dr Develin commented that it's a relatively small number, notwithstanding the importance of it. They are occurring under clinical guidelines. They are just not national guidelines at the moment. The NHMRC is being tasked to do a review to see what the appropriate national guidelines are. Professor Wesselingh hasn't completed that review yet and wants to draw on the best experts. So I don't think we can comment more than we can at the moment about that process.

Senator HANSON: I call on every parent out there who is going through this to please write to the department of health and tell them their concerns.

CHAIR: We will move to the next question from Senator Antic.

Senator ANTIC: These are questions for the TGA. Have we got everybody here?

Prof. Lawler: We should have the people you need in the room.

Senator ANTIC: Thank you.

Prof. Lawler: Depending, of course, on your questions.

Senator ANTIC: Understood.

Senator RUSTON: I have one question while we're waiting. Professor Kidd, how many times during the pandemic did the CEO use the powers of the Biosecurity Act?

Prof. Kidd: We would have to take that question on notice. I'm sorry; I wasn't in the role during that time.

Senator RUSTON: You were the acting CMO.

Prof. Kidd: I had a small number of periods where I was acting CMO during the period when I was the deputy chief medical officer, but I was away from the department for two years from the middle of 2023.

Senator RUSTON: Could you find out how many times the power was used and for what purposes?

CHAIR: Senator Antic, I think you have your officials.

Senator ANTIC: Thank you. In February 2021, the TGA produced a document called the COVID-19 vaccine safety monitoring plan. This is it here. I have copies if it needs to be tendered. In broad terms, it was a document in which the TGA spelled out their implementation plan for the monitoring of the COVID vaccines. A couple of months ago, I asked the Senate to order to produce documents from the TGA, including those showing the timely collection and management of reports of adverse effects; any safety signals and documents which show those; timely action to address and so on. Can you tell me whether or not that monitoring plan was used? Were documents collected? Are those documents available? I can spell them out later.

Dr Dascombe: I would say that the TGA has ample documentation demonstrating compliance with the principles and objectives of that COVID vaccine safety monitoring plan. The five key elements that are articulated in that plan essentially describe the process of post market surveillance and safety investigation that our medicines and vaccine surveillance teams follow at the TGA every day. Whilst there is no single specific evaluation report outlining or benchmarking us against the elements of that plan, there is ample information in the public domain which provides evidence of compliance with the plan and underscores our commitment to transparency as a regulator. Since the time you mentioned, February 2021, and the start of the COVID vaccine rollout in Australia, the TGA has investigated 148 safety signals for COVID-19 vaccines. Updates have been made to product information and consumer medicine information documents on 57 occasions, representing regulatory actions taken by the TGA. The TGA's database of adverse event notification captures and reports on information reported by consumers, health professionals and jurisdictions in Australia. That's all publicly available. In addition, the TGA has released a number of documents under freedom of information. There have been 70 requests directed toward our branch since February 2021. To summarise, I would say that each of those elements is evidence of us working toward the principles and objectives contained in that.

Senator ANTIC: But there will be documents that aren't in the public domain that were associated with the plan. What I'm proposing to do is to put on notice the request for those documents and ask for an undertaking that they will be produced to the committee. Is that something that can be done?

Dr Dascombe: There would be some difficulty in doing that. As I said at the outset of my response, the five key themes outlined in that report essentially describe our day-to-day processes. This is our standard sort of process in terms of post market surveillance and pharmacovigilance. There would be a vast volume of documents that would relate to our day-to-day work since February 2021.

Senator ANTIC: I don't think this is looking for vast volumes of documents. These are just documents that show that adverse events reports were being done. This is a public document which in its essence was designed to give confidence to the Australian public that this pharmacovigilance was taking place.

CHAIR: Senator Antic, can I seek some clarification from you? Is this a document that you have in your possession?

Senator ANTIC: It is. I have a copy.

CHAIR: Are you able to table it for the committee?

Senator ANTIC: I can. I have one here to tender.

CHAIR: Thanks very much. That is so the officials can reference it.

Prof. Lawler: I might highlight that we have had this conversation with your colleagues previously. Dr Dascombe has highlighted that we receive frequent and multiple freedom of information requests. We do endeavour to meet them. There are circumstances in which we are challenged in that. We are committed to transparency in our practices, as any Public Service operation should be. There are times when that is made difficult for a number of reasons. We articulate them in our decisions and the communication that is undertaken in our decisions. I would highlight that the COVID vaccines have been probably the most scrutinised and monitored therapeutic treatments that have been introduced in Australia in the last 50 years.

Senator ANTIC: So, with that, there should be no difficulty with providing the documents to show that scrutiny or pharmacovigilance has taken place in accordance with the document produced in February 2021. Why can't they be produced to the Australian public so that people out there who are interested in this subject can make their own assessment, with the greatest of respect?

Mr Henderson: I might also highlight through the pandemic that we were putting out weekly COVID-19 safety reports, which highlighted the number of adverse events that were being reported to the TGA. We then

moved to fortnightly. Through the pandemic, I believe that we put over 140 of those COVID-19 vaccine safety reports to the public.

Senator ANTIC: There are a lot of concerns about that process in the sense that it was deemed to be very complicated for adverse events that may not initially have seemed reasonable. We're also talking about five years down the track. There may be a lot of data that would be collected that wasn't during that period as well. With the greatest respect, it is my submission that these documents should be produced. I will put on notice the requests for documents. I ask that they be produced. At the end of the day, we can take the TGA's views on whether there's too much or too many or whatever. I think the purpose of the exercise and the purpose of freedom of information is to show people that what the TGA said was going to be done was done. That's the purpose of the exercise.

Prof. Lawler: Absolutely. I concur with you entirely on that. That's the absolute purpose. We're very happy to receive any requests for freedom of information. The matter of the order to produce documents is obviously outside our control in the TGA.

Senator ANTIC: Sure. This is as a result of this committee.

Prof. Lawler: Absolutely. We're very happy to receive any request for documents through the appropriate channels. Indeed, we've previously answered Senate questions on notice about those matters multiple times in this committee.

CHAIR: In interests of everyone's health and wellbeing in this wonderful committee, we will take a short suspension.

Proceedings suspended from 11:17 to 11:32

CHAIR: Before we get started, the media has requested permission to film and take some photos of proceedings. The committee has agreed to this. I remind the media that this permission can be revoked at any time. The media must follow the direction of secretariat staff. If a witness objects to filming, the committee will consider this request. The media is also reminded that they are not able to take images of senators' or witnesses' documents or of the audience. Media activity will 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. Thank you. We will continue in outcome 1 on health policy, access and support.

Senator WATERS: Hello, everyone, and good morning, Minister. I have some questions, firstly, about the sexual and reproductive health alliance STI awareness campaign. Have we got the right folk here for that? I will ask the question and see how we go. The right folk can come to the table.

Mr Comley: We will have the right people. They are on their way.

Senator WATERS: I understand that there is Commonwealth funding for an STI awareness campaign being run by the sexual and reproductive health alliance. An evaluation of the program is showing that it's working. People are booking screening tests. What we've discovered is that their targeted ads are being blocked by Google as adult content. In November last year, Google added STI testing to its list of sensitive topics, which triggers an automatic review. That has meant that, during the nationally funded STI awareness campaigns, ads were being rejected and delayed for weeks and costs have risen from $5 to $17 per click until the issue is resolved. Firstly, is the department aware of this? Secondly, if so, what is being done about it?

Ms Ringwood: Can you repeat the question for me?

Senator WATERS: Sure. The Commonwealth funded sexual and reproductive health alliance STI campaign is having its public ads blocked by Google because they've changed their terms and they are deemed adult content. That is obviously delaying the public health purpose of the campaign and leading to increased costs and frustration. Is the department aware of this? If so—hopefully you are—what can be done about it? What are you doing about it?

Mr Comley: I want to check. Ms Ringwood can then answer. We have a campaign called the Beforeplay campaign, which we have had in market. Is this a different campaign?

Senator WATERS: I'm not sure of the names of your department's campaigns. The sexual and reproductive alliance is being funded to run an STI awareness campaign. Hopefully you are aware of the name of your campaigns.

Ms Ringwood: That's not a campaign that the department has developed under the advertising guideline.

Senator WATERS: No. But the Commonwealth has funded it. What is the Commonwealth doing to ensure that the public awareness can flow?

CHAIR: Senator Waters, in the interests of letting the officials answer your first question, I note that Ms Ringwood had started speaking. If we can just wait for the answer before we continue.

Ms Ringwood: I will defer to Dr Develin to provide a response for this one. It's not something that we're aware of. It's not something that we've developed under the guidelines. I am certainly happy to take that on notice and look into it.

Senator WATERS: So the department is not aware that Google is blocking the ad campaigns that the Commonwealth has funded?

Mr Comley: Before we definitively say that, I would like to see either Ms Balmanno or Dr Develin. The issue we have here is that it's run out of the other part of the department, which is the grant funding for that body, if that's what I think has happened, not our comms area. I'm not going to definitively say that we don't know until we have the right people at the desk.

Ms Balmanno: We'll check on that.

Senator WATERS: Are you the right person?

Ms Balmanno: No. I think I have the right person here, though downstairs. We're assuming it's a grant that we're providing, so we'll need to find out more information about that one.

Senator WATERS: Great.

Ms Balmanno: We'll find that out now and come back to you.

Senator WATERS: That would be wonderful. Obviously, it's interfering with public health objectives and potentially wasting the Commonwealth money if the ads are only meant to cost $5 per click and they've gone up to $17 because Google is censoring actually what is a very protective public health campaign. I look forward to an update on that. I want to ask some questions about menopause following the Senate inquiry by this committee and the consensus recommendations therein. There was funding in the budget for a public health campaign to raise awareness. I would like to know what the time line on that is and who you have consulted on the content of that campaign.

Dr Develin: Good morning, Senator. I recall last time we talked to you about the campaign reference group. At that time, we hadn't established it. I'm happy to confirm for you that external advisory group to the campaign has been established. That includes representatives of organisations such as Jean Hailes, the Australasian Menopause Society and the Australian Longitudinal Study on Women's Health. We have Monash University, the Multicultural Centre for Women's Health, the RACGP and obstetrics and gynaecology. We've got consumers health. NACCHO is involved. There is LGBTIQA+, Allied Health Professions Australia and the National Rural Women's Coalition. We have a representative from the Victorian department of health, noting the work they have done in Victoria. I'm pleased to say that group will be providing us input into the campaign as it is developed. I will hand over to Ms Ringwood to give you the timeframes for the campaign.

Ms Ringwood: Senator, the campaign is currently in development. At the moment, we are talking to people within the target audience for the campaign. We are undertaking research to help inform the communication strategy and the creative content of that campaign so we can be confident that it is evidence based and audience informed. We are looking to be rolling that campaign out in the new year subject to government approvals under the guidelines, of course.

Senator WATERS: Who have been identified as the target people?

Ms Ringwood: The target audience that we're talking to is women aged 35 to 55 years old.

Senator WATERS: How will you ensure that the information is going to be helpful for everyone and, in particular, reach Aboriginal and CALD women?

Ms Ringwood: So we will be working closely with First Nations and multicultural suppliers on the development of the campaign as well. We are looking to engage closely with those audiences on the development of the strategy and the content of the campaign for them as well.

Senator WATERS: The TGA website says once again that there's a shortage of various MHT patches. Given the likelihood of an awareness campaign increasing demand for treatment, will you work with the TGA to secure supply and ensure that any extra demand created by the campaign can be met? I do have some separate questions for them.

Dr Develin: Just in relation to the campaign, I think the campaign is unlikely to recommend what women should do specifically. As you can imagine, every woman's needs are different. We do anticipate that the campaign is more likely to raise awareness of the symptoms so that consumers are more likely to be aware of the

symptoms but then seek health professional further advice. It's more likely to point consumers to go see their health professional if they are concerned or they have any questions about symptoms as opposed to recommending a particular course of treatment or action.

Senator WATERS: I understand that. It may naturally increase demand where there's already a shortage. Have you got that on your radar? What are you doing to work with the TGA to minimise existing shortages that might get worse when demand increases, if demand increases?

Dr Develin: I'll refer to the TGA.

Mr Henderson: Thank you for the question, Senator. As you highlight, there has been an ongoing shortage of HRT treatments. We have looked to provide alternative options through our 19A mechanism. There are a number of 19A approvals for alternatives to manage and mitigate the impact of those shortages. We've also put in place what we call a scarcity substitution instrument, whereby pharmacies can, at the point of dispensing, rather than go back to the prescriber, provide an alternative product to the patient. I might defer to my colleague Dr Fenner to go into more details about the measures.

Senator WATERS: I probably don't need more detail because we did cover the processes available quite extensively in that excellent inquiry. Maybe on notice if you could provide that to me, that would be great. I have only a short period here.

Mr Henderson: Will do, Senator.

Senator WATERS: I am informed that there has not been a new HRT patch added to the PBS for, from memory, at least 20 years. Firstly, is that true? Secondly, how are you encouraging some of the more modern manufacturers to seek PBS listing?

Mr Henderson: Well, I can't talk to the PBS, Senator, but I can talk for the TGA. In relation to encouraging more sponsors to come forward, we do have a very open invitation for things such as pre-submission meetings. We do offer that opportunity for sponsors to come forward and talk through potential products that they may have coming through. We also have what we call pipeline meetings, where we discuss with sponsors the products that are coming through, their clinical trials and other aspects in that drug development process. We try to give them that as well as great insight in relation to how those products could go through the regulatory pathways.

Mr McIntyre: I would need to take on notice when the last time an HRT patch was listed on the PBS. We are actively managing the products on the PBS. We have various ways of managing things that are close to shortage that we've introduced over the last five years or so. We're increasingly able to use them with the existing sponsors of HRT medications. We have a minimum stockholding requirement for drugs listed on the PBS that meet certain requirements. There are a number of brands that are becoming designated brands for those processes. There are four new designated brands of HRT patches. That means that, as supply is available, we are requiring that those sponsors provide a six-month supply in Australia and that they provide assurance that they can do so and that they have notification obligations in instances where they are unable to maintain that supply. Many of the issues associated with the HRT medications are global supply chain issues. They are affecting all countries, not just Australia.

Senator WATERS: Yes.

Mr McIntyre: We increasingly have mechanisms such that we can get more surety and therefore manage the stock that we are able to get in Australia in a way that ensures it gets to the patients who are most in need.

Senator WATERS: Thanks for that. I remain of the view we should be locally manufacturing, but that's above yours and my pay grade, so to speak. There is the new MBF listing for menopause and perimenopause health assessments. Is it possible to get, perhaps on notice, the first quarter data on how many people have used it? Can I get a nod that we can get that on notice?

Dr Develin: We'll take that on notice.

Senator WATERS: Great.

Mr Comley: We now have people from the interim CDC who could answer-—

Senator WATERS: The first question?

Mr Comley: Yes.

Senator WATERS: Yes, please. That would be great. Thank you.

CHAIR: Senator Waters, you have just over five minutes before I hand over the call.

Senator WATERS: Hello, folks. Presumably, you're across Google blocking public health awareness raising ads on STIs. I'm keen to know what the department is doing to rectify that.

Ms Charleton: We are aware of the issues that have been created by Google in blocking these ads. We have discussed them with Australasian Sexual and Reproductive Health Alliance. At this point in time, we have not been asked to escalate the issue any further. We understand that the campaign is actually performing quite well and it's meeting and exceeding all of its metrics.

Senator WATERS: Do you mean the alliance hasn't asked you or the minister hasn't asked you?

Ms Charleton: The alliance hasn't asked us.

Senator WATERS: Okay. So the government is happy with ads costing $17 per click rather than $5 per click? Won't that mean that you can't get as many ads out with the limited budget that you've got?

Ms Charleton: We have discussed it with ASRHA, and we are meeting all of those metrics. At this time, the campaign is actually performing to the standards that have been set for it.

Senator WATERS: It sounds to me like the alliance ended up resolving it directly with Google. Well done to them. Shouldn't the department assist so that future public health campaigns aren't impeded by Google's strange definitions of what is and is not adult content?

Mr Bouwhuis: We generally work with the stakeholder. So where we're funding someone under a grant arrangement, we'll have the conversation with them about how to proceed. In this case, they've had the conversation with the organisation and it has been resolved subsequently.

Senator WATERS: So it's not your job to fix Google? You think it's their job to have that argument? It doesn't seem great to me from a public health perspective.

Mr Bouwhuis: Senator, it's a conversation with them about how best to proceed.

Senator WATERS: Does government have a policy on dealing with public health campaigns, not just this one but generally, when Google decides something is adult content in a way that makes the expenditure of Commonwealth funds inefficient and that costs more taxpayer dollars and, therefore, reaches fewer people? I don't think that should just be left to the people who are doing the work. I think that should be government's concern. I would like someone to let me know how you are approaching that, please.

Ms Balmanno: If the organisation had sought our assistance, we would absolutely raise that with Google. At the point they raised it with us, they were in ongoing discussions with them about the nature of the content and the charging and those things. They haven't sought us to specifically intervene. Absolutely we agree that were this to continue to be a problem and to block the effectiveness of the campaign, that would be a role that we could assist with.

Senator WATERS: Do you have a policy on how you will deal with that in future? Is it a wait and see until it happens again?

Ms Balmanno: We don't have a specific policy. It goes to the different social media and search platforms that are always evolving. We do obviously have quite a large following ourselves as an organisation and have worked quite closely with those platforms, particularly during the pandemic, to make sure that public health information is surfaced appropriately and available. So we have those relationships and the ability to influence where we need to.

Senator WATERS: Okay. You just wait and it's a case-by-case thing? You don't have a policy of reaching out to say, 'Here's our new campaign. Don't block it?'

Ms Balmanno: While it's funded through a grant by the Australian government, it's not a government campaign. It's not an authorised government campaign, so it's not our campaign to launch and to advocate for in that way.

Senator WATERS: Do you factor into the amount of the grant the time that the organisation will have to spend hassling Google to not get in the way of a Commonwealth funded public health program, or do they just have to suck up that cost and time in fixing it directly with Google?

Ms Balmanno: The size of the grant is not something in this case I have any visibility of in terms of that. As Ms Charleton said, the campaign itself is performing. In terms of Commonwealth funds being used for this purpose, it is achieving the purpose that it was provided for.

CHAIR: Senator Waters, I need to share the call.

Senator WATERS: Just one final question, if you don't mind, Chair, for clarity. Do grants factor in the time and money that a grant recipient will have to spend arguing with Google? Do you consider that they just have to suck that up in the cost of the campaign? If that's not you personally, perhaps the actual government can answer.

Senator McCarthy: Chair, I will step in here, if that's okay. Senator Waters, thank you for your questions. This is the first I've heard of it in terms of what happened with Google and to hear the responses from the department here. I will follow this up with the minister. We'll certainly follow it up with the communications minister as well.

Senator WATERS: Thank you.

Senator LIDDLE: I will ask those officials that were here before to come and talk about Aboriginal health. I will get some context, which I'm sure they're already aware of. In 2022, there was a significant diversion of funds into Central Australia following the lifting of the alcohol restrictions under the Commonwealth program that had been in place for many years known as Stronger Futures. It had a catastrophic effect. I am just trying to unravel where the money has gone. Significant harm has been caused by alcohol in that community. As you know, there was a leadership group formed of a number of organisations in Central Australia. It provided advice on where that money should be spent. Yesterday I was told that the department of health had some responsibility. That brings me here.

My question goes to the Central Australian Aboriginal Congress, the Ooratippra Aboriginal Corporation, the Central Land Council and Tangentyere Aboriginal Corporation. They essentially got millions and millions of dollars to address the catastrophic harm of lifting those alcohol restrictions in 2022. I want to go to a question of your due diligence in decisions made about where funding should go. I was trying to find an analogy for this. I want to understand how it is that your due diligence, which we so often hear about, failed to identify that some of the organisations that received money to address the harm of alcohol misuse and abuse also have commercial interests in selling alcohol in Central Australia. The analogy for that situation that I came up with is that the federal government and government departments have effectively given money to the vampires, who are now in charge of the blood bank. I want to understand how your due diligence did not pick that up.

Ms Street: Are you talking about a particular grant from this department that has been undertaken in the NT? In relation to that package, we didn't have, as I understand it, any elements that were for alcohol and other drugs that I'm aware of.

Senator LIDDLE: Let me help you with that.

Ms Street: Thank you.

Senator LIDDLE: Have you given any money at all in your grant programs to the Central Australian Aboriginal Congress?

Mr Barratt: Yes.

Senator LIDDLE: That's a 'yes'. Have you given any money from your programs to Ooratippra Aboriginal Corporation?

Ms Turner: Not that I'm aware, no.

Senator LIDDLE: Not for drug and alcohol or domestic violence programs, FASD or anything like that?

Ms Street: Not from the Indigenous Australians health program. But we can take on notice whether or not there is any through our other programs, Senator.

Senator LIDDLE: Okay. Not Tangentyere Aboriginal Corporation?

Ms Turner: No.

Senator LIDDLE: Doesn't ring a bell? Let's talk about Central Australian Aboriginal Congress, which got a significant amount of money to address FASD and does some terrific work in administering health in Central Australia. My issue is actually with an organisation that has in the last three years got significant amounts of money to address the harm that has been caused from alcohol. Yesterday we heard from the Central Land Council, who was a shareholder of a business. They couldn't tell us what businesses that company is involved with despite the fact that it is a majority shareholder, Central Australian Aboriginal Congress is a shareholder and Tangentyere Aboriginal Corporation is a shareholder. I want to understand your due diligence around organisations such as this. I am all for business development and opportunity. How is it that health money has gone to organisations without, it appears, people understanding that they have associated entities where they are directly involved in selling alcohol in Central Australia? I want to understand how the government bureaucracy doesn't pick that stuff up. I want to understand. Minister, maybe you can help me understand.

Senator McCarthy: Sure.

Senator LIDDLE: You have a federal member of parliament there. How is it that there has been so much silence around this?

Senator McCarthy: Senator, we might have to get some more information from you with regard to your allegations against Congress. Congress, I'm sure, can speak for themselves. To my understanding, they have no interest in alcohol. Unless there's a specific piece of information you have there that you would like to table, to our understanding, there is no vested interest with alcohol other than to assist their patients to overcome the effects of alcohol.

Senator LIDDLE: What I will inform you, and you heard yesterday, is that the ANAO has done an audit. They went to the Central Land Council and asked for more information because they identified an associated entity that required more information. The Central Land Council was really clear yesterday that it is a shareholder, sure, but it doesn't get a drawdown from those shares. But it is an associated entity. It has a connection to it. In that instance, it needed to, under the instruction of the ANAO, put more detail in its annual report about that relationship. But the other shareholders are Central Australian Aboriginal Congress and Tangentyere Aboriginal Corporation. I'm not saying they get a return from that.

Senator McCarthy: But at no point was alcohol mentioned in that. I think, Senator, in your allegation against Congress, we would need to see documents that connect Congress to alcohol in order for the department to be able to responsibly respond to you.

Senator LIDDLE: I have just explained the ANAO discussion held yesterday. You sat in that discussion.

Senator McCarthy: I did. But there was no mention of alcohol. With regard to your questions to the CLC, it was about their participation and shareholding in an entity. But there was no conversation in that, in any of those estimates yesterday, around alcohol. I'm saying that if you have documentation, I'm happy to respond to it. Do you have information with regard to alcohol and their involvement in it? It was not in any context in the conversation yesterday.

Senator LIDDLE: Minister, I will put to you that the question is around due diligence in understanding any connections.

Senator McCarthy: That's fine. Absolutely.

Senator LIDDLE: I gave you an explanation that there are other entities as well. I'm trying to understand how government departments do their due diligence. I keep hearing that they are doing it. How many more organisations perhaps have associated entities that we are not aware of and then we become aware they have connections to the very thing we are actually trying to address?

Senator McCarthy: It would be good to-—

Senator LIDDLE: I'm not saying-—

Senator McCarthy: But I need to understand the allegation. This is where we're not clear.

Senator LIDDLE: The allegation is a due diligence one.

Senator McCarthy: But you're talking about alcohol with regard to due diligence. I need to understand whether you are accusing Congress-—

Senator LIDDLE: Don't keep going back to Congress. I've named a number of organisations. I'm asking-—

Senator McCarthy: Congress is all that the department have said they fund. I have to refer to Congress.

Senator LIDDLE: Okay.

CHAIR: Minister and Senator Liddle, what I heard is that the minister is happy to receive additional information to help get some more clarity on the purpose.

Senator McCarthy: Absolutely.

CHAIR: Are there any other questions for officials in the First Nations health division that you have?

Senator LIDDLE: I want to know what the department will do regarding corporations or organisations. They don't have to be Indigenous; they can be anybody. What do you do to understand the associated entities that might have a bearing on the integrity of the work you are trying to do and they are trying to do? How do we actually improve that?

Ms Street: What I would add to that is that, as part of any procurement or grants process, we do look at things such as conflicts of interest. I can't talk about this case. There's an element in terms of people disclosing conflicts of interest. That would be part of our due diligence processes.

Senator LIDDLE: I know that the minister is compartmentalising this to the entity that you actually directly fund. Regardless, any money that comes from the Commonwealth, from the taxpayer, that goes to addressing these issues is going to have a blowback to you from a health perspective. That's why I'm asking the questions in

here. Ultimately, it's going to have blowback in a health consequence. How do we actually make sure that the due diligence is done better?

Mr Comley: We can take on notice how we can do it. What I'm mindful of is that if we in all of our grants processes tried to track every associated entity with everyone we deal with, it would be a very difficult and onerous thing to do. We do rely on, in some cases, the declaration of conflict by grant recipients. We follow up from time to time to see whether they have any other information on conflicts. We're happy to provide on notice details of how we do this, but there is a balance here between the other criticism we have, which is the speed with which we actually do get grants or commitments out the door and how long those processes take with tracking every associated entity. So I'm happy to take that on notice to reflect on our policy and whether we've got that policy right. Having worn other hats, I know how difficult it is to trace through all associated entities.

Senator LIDDLE: Can you take on notice how you are actually going to make sure that at least that question is asked? As in the case where the ANAO has identified that the question wasn't sufficiently answered, at least there's a mechanism there if you ask the question in the first place. I want to understand how you ask that question in future.

CHAIR: Thank you, Senator Liddle. Have you finished? Great. I'll go to Senator Ananda-Rajah.

Senator ANANDA-RAJAH: I have some questions on bulk-billing, if we have the right people here.

Mr Comley: Bulk-billing is individual benefits, which is under outcome 2. I will take guidance from the chair as to whether you want to take this here or under outcome 2.

Senator ANANDA-RAJAH: What about the urgent care clinics? Where does that fall? In 1.6?

Mr Comley: Yes, urgent care clinics does fall under 1.6.

Senator ANANDA-RAJAH: Let's talk about the urgent care clinics. The urgent care clinics are a relatively new discipline in health care. We introduced it in 2022. Could you provide us with a bit of an update as to what has happened since 2022, when we were elected, with the urgent care clinics?

Dr Develin: Good morning, Senator. As you are aware, the government's commitment has been $1.4 billion over seven years from 2022-23 for the urgent care clinics. We now have 90 open. There is a commitment to get to 137. We expect to do that. We are seeing that the clinics are serving the purpose they were intended for. We are seeing acute injury being about 27 per cent of the presentations; acute illness making up about 63 per cent; and a very small number being an exacerbation of a chronic condition. Just under one-third of the patients seen by the urgent care centres are under 15 years of age. A significant proportion-—around 29 per cent of presentations-—are on weekends. A really significant proportion-—about 25 per cent-—are after 5 pm on weekdays. So we are seeing from that data that they are serving the purpose they were intended for in terms of the sorts of presentations they are seeing and making urgent care available in the weekend and after hours.

We did release earlier in the year the first evaluation report, which will be one of a series of three. We have seen some very promising findings in the early evaluation. The wait time is relatively low in an urgent care clinic.

Senator ANANDA-RAJAH: What is it?

Dr Develin: I think it is about the 14- to 15-minute range. For those sorts of presentations that you might see in an emergency department, you can imagine a lot longer for those triage categories 4 and 5. There's a general sense that many of the patients seen in an urgent care clinic say they would have gone to an emergency department should the clinic not have been available. Again, we are seeing that consumer behaviour of seeking out the urgent care centre rather than attending an emergency department. We also in the evaluation saw very high numbers of referrals, where the people were sent to their GP with some sort of information or given some sort of written documentation. A very small number of patients are referred to emergency, which would suggest again that the clinics are serving their purpose.

Senator ANANDA-RAJAH: Could you table that report for us later when it's available? How many patients have used urgent care clinics now, do you think?

Dr Develin: We've seen 1.9 million presentations.

Senator ANANDA-RAJAH: That's incredible. In terms of the other way around, do you have a sense of how many patients have been referred from emergency departments to urgent care clinics? Is it in that report as well?

Dr Develin: In the evaluation report, the information we have is that 46 per cent of patients say they would have gone to the emergency department if it had not been available.

Senator ANANDA-RAJAH: Have you got any qualitative data from patients as to how they have responded to the urgent care service?

Dr Develin: From information in the evaluation report on our website, the sense from patients is that they really value having an alternative to the emergency department. The two key reasons for that are the avoided waits, as you can imagine, and the free service in the sense that it's bulk-billed and they don't have to pay.

Senator ANANDA-RAJAH: It's a free service, bulk-billed. What impact has this had on Australian emergency departments?

Dr Develin: The evaluation report very clearly says that you would need at least 16 months of data for each urgent care centre, which is then matched to the relevant emergency department to make sense of it. That's because emergency department presentations can be seasonal based on tourism, population growth and other things that have happened in the community. So you need to see the data for over a year. The evaluation was mixed. In some cases, we had seen emergency department wait times reduced for the triage categories 4 and 5, which would suggest that they are being seen somewhere else. In other parts, it was a more mixed result. So we do anticipate that evaluation reports 2 and 3 will give us further information about the impact on emergency departments.

Senator ANANDA-RAJAH: I gather that in one urgent care clinic in Launceston there was an improvement in the local hospital. Do you have any information on that?

Dr Develin: I will see if any of my colleagues have the specific data for Launceston for you.

Senator ANANDA-RAJAH: Do you have that data?

Ms Sinclair: I do have that data.

Senator ANANDA-RAJAH: Amazing. Please share.

Ms Sinclair: For the Launceston General Hospital, in 2023-24, they averaged around 1,200 category 4 and 5 presentations per month, which equated to about 281 presentations per week in those categories. In comparison, the Medicare urgent care clinic in Launceston treated around 509 visits per week in July and 516 visits per week in August for those same conditions.

Senator ANANDA-RAJAH: That's fantastic. Professor Kidd, there was some resistance in the medical profession before we introduced this in 2022. How do you think the profession has responded, particularly general practitioners?

Prof. Kidd: Thank you, Senator. Too right there were initial concerns about whether the establishment of urgent care clinics was going to have an impact on continuity of care, whether it was going to further fragment care and whether it was going to have an impact on the workforce in general practices. I think that as we've seen through the evidence provided by Dr Develin, there has been huge community uptake of the urgent care clinics. We've also seen a lot of engagement and communication between urgent care clinics and the general practices where patients may normally receive their care. So the continuity of care is continuing. Of course, we've seen a large number of general practitioners doing some of their work in these urgent care clinics as well as in their regular general practices.

Senator ANANDA-RAJAH: Have there been any issues recruiting GPs into these clinics?

Mr Roddam: GPs are, generally speaking from the evidence, enjoying work in the clinics and enjoying the variety that it brings to their working lives, as Professor Kidd said. As we get into more regional areas, as in generally with the health workforce, there can be more difficulties in recruiting medical staff, including general practitioners. But it has proved a very attractive model to the workforce.

Senator ANANDA-RAJAH: We have 90 that are operating now. We're heading towards 137. How are we tracking? Do you have a time line as to when you want to see 137 delivered?

Mr Roddam: There will definitely be all 137 this financial year, Senator. We would expect to see a significant number opened this calendar year as well.

Senator ANANDA-RAJAH: That's fantastic. Have you had any expressions of interest from seats or electorates where there aren't any urgent care clinics? Perhaps local MPs have written letters to the minister.

Mr Roddam: It's a very popular model. Yes, we do get representations seeking urgent care clinics.

Senator ANANDA-RAJAH: Would you be able to give us a breakdown of how many MPs from other electorates-—electorates that don't have an urgent care model-—have actually made a petition to the minister?

Mr Roddam: I would need to take that on notice, Senator.

Senator ANANDA-RAJAH: That would be wonderful, including the breakdown of where they are et cetera. Finally, with the expressions of interest, can you give us an update on how that is going with the next tranche of clinics that you want to roll out-—the 90 to 137?

Mr Roddam: Yes. In all cases for the remaining 47 clinics, Senator, the commissioners are undertaking or have undertaken an expression of interest process at the moment. They are largely in the field.

Senator ANANDA-RAJAH: Can you just talk me through briefly how that expression of interest occurs? Is it through the PHNs?

Mr Roddam: Yes. In every jurisdiction for the new clinics, apart from the Northern Territory, the local primary health network is the commissioner. They undertake that process.

Senator ANANDA-RAJAH: Finally, I'm interested in one-third being children under the age of 15. Are you able to give us a bit of an overview of what kind of conditions children are presenting with? I can imagine that's a big win for families and parents.

Dr Develin: Indeed. As I said, about 30 per cent of presentations are people under 15 years of age. The most common sorts of presentations are acute injury at about 27 per cent. You can imagine as a parent that Saturday afternoon becomes pretty busy after the weekend sport, as many of us have experienced, or with the acute illness, which is about 63 per cent. You might get earaches, gastro and other things that affect young children that parents want urgent care for.

Senator ANANDA-RAJAH: Do I have time, Chair, for one more?

CHAIR: One more question.

Senator ANANDA-RAJAH: One more. It is about the diagnostics required after a consultation, be it imaging or pathology. Where do parents and patients go and get that care? Is it on site or separate?

Dr Develin: There are varied arrangements. I will let Ms Sinclair talk you through the varied arrangements.

Ms Sinclair: All Medicare UCCs are required to have local arrangements in place for diagnostic imaging, be it X-ray, access to a CT or ultrasound. Those requirements are outlined in the operational guidance. That could include pathways to services on site or proximate local arrangements in place with other local service providers.

Senator GROGAN: I can tell you about my experience of taking a child-—not under 15, by a long shot-—with a broken leg to an urgent care clinic. It was amazing. It was late on a Saturday afternoon. They were just brilliant. I love my urgent care clinic.

CHAIR: Thank you, Senator Grogan, for that contribution from the government senators. I'll go to Senator Antic.

Senator ANTIC: I have questions again for the TGA, picking up a bit from where we left off. I want to ask some questions about the childhood immunisation schedule. I will start with a broad question. How many vaccines are children scheduled to receive from birth to adolescence? How many diseases does it cover, as it is currently standing?

Prof. Lawler: I might get some clarity from you. While the TGA undertakes the pre-and post-market authorisation and monitoring of vaccines and other therapeutic goods, we're not in charge specifically of the immunisation schedule. I might refer that question to Dr Anna Peatt from the national immunisation division.

Dr Peatt: First of all, all vaccines that go on the national immunisation schedule go through the Therapeutic Goods Administration assessment. They are also recommended by ATAGI. They also go through a Pharmaceutical Benefits Advisory Committee assessment.

Senator ANTIC: I will come to those questions. I will simply start with the first one. How many are there?

Dr Peatt: We've got 31 vaccines in total.

Senator ANTIC: For how many diseases?

Dr Peatt: For 18 diseases. That is for adults and children. For children, I think it's about 16. We'll have to take that on notice.

Senator ANTIC: You'll take on notice how many?

Dr Peatt: Yes. The vast majority are for children.

Senator ANTIC: Of those vaccines, how many placebo control studies have been done on vaccines on the childhood schedule?

Dr Peatt: That would be a very difficult question to answer. The TGA might be able to add to it. They do the initial assessment on the safety and efficacy of the vaccines.

Prof. Lawler: I will ask Dr Nitin Bagul, who is one of our senior medical officers, to come to the table to respond.

Dr Bagul: Thank you, Senator, for the question. Can I please ask you to repeat the question in relation to the vaccines?

Senator ANTIC: Yes. The question is: how many placebo control studies have been done on vaccines on the childhood schedule?

Dr Bagul: I will take that question on notice. I don't have it to hand at the moment.

Senator ANTIC: You need to take that on notice?

Dr Bagul: Yes.

Prof. Lawler: I will highlight, if I may, that this is a question that has also been asked of other regulators. I think part of the challenge we that it is frequently held that placebo controlled or double blinded or randomised control trials are the gold standard in science. Certainly in the introduction of new medicines, particularly when there's no established standard of treatment, that is often the case. There are fairly substantial ethical questions to be answered around introducing a placebo control trial when there is a demonstrated effective medication that is used to either prevent or treat. For instance, given that we do have demonstrable efficacy of vaccines or vaccine-preventable diseases, it would be ethically not only questionable but probably not arguable that a placebo control trial would be appropriate. You would actually have to specifically not vaccinate children and expose them to disease that we know has serious morbidity and when we also know we have an effect.

Senator ANTIC: So these are injections that we're giving to almost every child in the country at the moment. We can't say at this stage-—you have to take on notice-—how many placebo control studies have been done, which is the gold standard?

Prof. Lawler: No.

Senator ANTIC: It's not the gold standard?

Prof. Lawler: I might try to explain it in a different way, Senator. The gold standard for science is contextual. When there are new treatments to be determined, absolutely there is a preference for a placebo control trial so you can compare a control arm with an intervention arm. That way, you're able to remove a number of the confounding factors and demonstrate both the risks and benefits of that treatment. When there is an established treatment for which there is not only demonstrated efficacy in terms of preventing the disease and the consequences of the disease but also decades of real-world evidence on the safety and a positive risk-benefit analysis, there is the lack of an ethical basis for a placebo control trial. Where, as I say, there is an accepted and efficacious treatment for a significant disease with significant morbidity, that cannot be described as gold standard.

Senator ANTIC: How many are we talking about? Many of these cover multiple antigens. I think in 1990 the full schedule was 21 antigens. Now it is about 60. With that in mind, what placebo control safety studies have been done examining the combination of multiple antigens in these injections?

Prof. Lawler: Thank you for that question, Senator. The evolution in the immunisation schedule-—again, it is something that Dr Peatt might like to comment on-—has been cited as a challenge. It has been in some quarters—and I'm not suggesting that you are doing this at all, Senator—spuriously associated with the rise in certain diseases or disease states. The reality is that the antigenic load experienced by children has decreased over the years despite the fact that the number of antigens which provide-—

Senator ANTIC: How is that?

Prof. Lawler: The volume of the antigenic load.

Senator ANTIC: With that in mind, then, I will go back to the question. What placebo controlled safety studies have been done examining that reduced antigen load?

Prof. Lawler: The comment about the antigenic load is not around the impact or the immunogenic response in the patient. It's about what is presented. There is an enormous amount of work that is being undertaken by ATAGI on a regular basis in recommending what goes into the schedule. That's one of the considerations. I think, as Dr Bagul has said, we will provide you with information. Given the number of vaccines and the number of diseases for which we vaccinate, it would be more appropriate, I think, for me to provide that information.

Senator ANTIC: I'm staggered that can't be provided now. I will go back to your point.

Prof. Lawler: We will give the information on notice.

Senator ANTIC: Alright. Excuse me. This is a complicated area and I'm a layperson. To summarise, you say placebo control studies are difficult when there's a history of the use of the product later down the track. Infanrix hexa was approved, I think, in June 2006. That covers a range of antigens. I want to specifically look at that. It

might be easier if we look at one. How many adverse effects in total have been reported for that drug both internally and externally since it was introduced?

Prof. Lawler: While I'm waiting for Dr Dascombe to come to the table, I wouldn't mind addressing the fact that I didn't say-—

Senator ANTIC: Sorry. I don't want to put words in your mouth.

Prof. Lawler: I want to be really clear. I didn't say that a placebo control trial for these vaccines would be difficult. I said it would be ethically indefensible or ethically difficult. The ethics around a deliberate process of infecting a child whom you know to be unvaccinated when there is demonstrable efficacy and safety with those vaccines, I think, is difficult to defend ethically.

Senator ANTIC: Okay. That is a moot point.

Prof. Lawler: I would say that's not just my opinion. That is fairly broadly held.

Senator ANTIC: It's a convenient opinion, though?

Prof. Lawler: Well, it may be convenient. That doesn't stop it being true.

Senator ANTIC: Convenient. I will return to the issue of adverse effects in total for Infanrix hexa internally and externally since it was introduced.

Dr Dascombe: Thank you for your question, Senator. I would say that the TGA maintains a robust system of post-market surveillance for all vaccines, including Infanrix hexa. We publish publicly on our database of adverse event notifications all adverse event reports received for all registered medicines and vaccines, including that vaccine. In terms of the specific number, I would have to take that on notice and come back to you, Senator.

Senator ANTIC: I want to ask a separate question. Recently, on 5 September 2025 in the United States Senate Committee on Homeland Security and Governmental Affairs, a report was produced. It was the Henry Ford health study. It's an unpublished retrospective study comparing health outcomes in 18,000-odd children born between 2000 and 2016. Just under 2,000 children were unvaccinated and 16,000 were vaccinated. It showed that vaccinated children had statistically significant rates of chronic conditions-—three times atopic disease, just over four times asthma, 5½ times neurodevelopmental disorders and 5.96 times autoimmune diseases, to name a few. It's pretty concerning stuff. Is the TGA aware of that study of outcomes between vaccinated and unvaccinated children? If so, have there been any internal reviews or assessments of its methodology and preliminary findings, noting that it was the US Senate that it was produced to?

Prof. Lawler: I don't feel that we're in a position to provide a significant or detailed critique on that.

Senator ANTIC: Are you aware of it?

Prof. Lawler: I'm aware of the report. I know that it has-—

CHAIR: Senator Antic, can I get you to table it?

Senator ANTIC: I don't have the report on me, but I can table it later, yes.

CHAIR: If you can send it to the secretariat, that would be great. Thank you.

Prof. Lawler: I'm aware that it has been commissioned by a non-profit vaccine safety organisation called the Informed Consent Action Network. The motivations and methods of these groups are not always clear or transparent to external review or critique of articles or reports. I also note that it is an unpublished draft currently. We are not really in a particularly strong position to assess that. I would say also that, in line with our pharmacovigilance practice, we do incorporate signals from a variety of sources-—our adverse event reporting, discussions with health professionals, conversations with other regulators and publications in peer reviewed journals. Indeed, we do maintain an open eye to even unpublished drafts from non-profit advocacy organisations.

Senator ANTIC: I have one final question before I hand the call back. A number of weeks back, the US government released some information about the use of paracetamol in pregnancy. It was suggested that there were some developmental risks for children. The makers of one of the paracetamol drugs, Tylenol, in 2017 tweeted: 'We don't actually recommend using any of our products while pregnant. Thank you for taking the time to voice your concerns today.' I see that the TGA on 23 September released a press release suggesting that the use of paracetamol in pregnancy is okay. Can the TGA confirm that the use of paracetamol when pregnant is safe and has no causal link to any developmental disorders?

Prof. Lawler: Thank you for that question and thank you for the opportunity to discuss this. This is a very important issue and obviously has generated a significant amount of excitement and interest. The TGA and the CMO-—I think I can speak for Professor Kidd-—were very pleased to have the opportunity to make public comment on this matter. Obviously, determinations and announcements by the US government are a matter for

them. Questions about that should be directed to them. On the issue of paracetamol safety, I think it is important to note that the statement that was made by the commissioner of the FDA-—the scale is different, but his role is broadly comparable to mine-—was that there is an identified association between paracetamol and autism in pregnancy. An indication was made that they would write to all doctors in the US. A communication went out from the FDA on 22 September saying, and I am reading here:

To be clear, while an association between acetaminophen-—

which is the generic name for paracetamol used in the US-—

and autism has been described in many studies, a causal relationship has not been established and there are contrary studies in the scientific literature.

There was a study that was cited that showed potentially a mild association between the use of paracetamol in pregnancy and autism.

I think it's important to make a brief aside at this point to clarify the distinction between association and causation. Association is a situation in which two things occur at the same time that can be demonstrated statistically. Causation is when one causes the other. The reason that's important to note that is that earlier this year a study was published by Ahlqvist which looked at about 2.5 million births in Sweden over a significant period of time. It was able to remove a number of confounders, which are external factors that can change the way a study comes out. Most importantly, they were able to correct for various variations. Very importantly, they were able to undertake sibling matching, which meant that they looked at pairs of siblings that you would assume had exactly half the same genetic profile, the same maternal health issues and predominantly the same environmental issues, one of whom had paracetamol and one of whom had not had paracetamol. What that study showed-—the largest study to date-—is not only is there not a causal link between paracetamol and autism but there is not actually an association.

We recognise that this has been potentially a very difficult time for people with autism and for mothers, who potentially are struggling with some of the decisions they made. This could have caused particular issues. One of the very important things that Professor Kidd and the TGA were very keen to say is that yes, indeed, it is still regarded as a category A drug, which indicates that it is safe and effective in pregnancy.

There are a couple of other things I would say that I think are really vital here. There are very few alternatives for pain and fever treatment in pregnancy. A number of the other drugs that you or I would take are simply not appropriate at any stage of pregnancy. It is important to note that one of the confounders is actually the fever of the condition that is being treated with the paracetamol.

CHAIR: Senator Antic, I need to share the call in a second. I will get one last question from you.

Senator ANTIC: First of all, how much do you recommend for pregnant women, and how much do you recommend for pregnant men?

Prof. Lawler: Paracetamol is a medicine that has been used and is regarded as safe and effective when used as directed. Every medicine that we have on the Australian Register of Therapeutic Goods has both product information and consumer medicine information. There are directions. We have seen the suggestion that you should not take paracetamol unless you need it in pregnancy. That's true for every medicine in every situation of life. You should take medicine only when you need it. I do also believe that it's important that conversations around medicine, when you are unsure, should be undertaken with your trusted health practitioner.

CHAIR: I am going to go to Senator Waters.

Senator WATERS: I will harken back to the reproductive health care inquiry conducted by this committee several years ago now. It has been more than two years since that inquiry issued our report, ending the postcode lottery, which was again a consensus report on women's health. I would like some updates on progress on the recommendations. In particular, I'm interested in the recommendation for essentially a national one stop shop information portal for people seeking help with repro health services. The recommendation was for a national portal. Has anything been done with the states or anyone to develop that tool?

Ms Clancy: I'm just working through to figure out which recommendation number that was. There are quite a number and I do have notes against all of them.

Senator WATERS: Thank you. I don't have that number to hand, I'm sorry.

Ms Clancy: It is one we could get for you later this afternoon as well. There was a recommendation that the Australian government, in consultation with state and territory governments, implement a national support information referral model.

Senator WATERS: That's the one.

Ms Clancy: For sexual and reproductive health services.

Senator WATERS: Thank you.

Ms Clancy: A feasibility study for Healthdirect to address the recommendation has been completed. The outputs from the study were to be delivered to health ministers earlier this year. However, the department has been looking to conduct additional research and stakeholder consultation before it will seek to finalise the study.

Senator WATERS: Okay. I couldn't quite catch all of that. Could you say that again and a little more slowly?

Ms Clancy: A feasibility study for Healthdirect to address the recommendation has been completed. The outputs from the study were to be delivered to health ministers earlier this year. However, the department is seeking to conduct additional research and stakeholder consultation, which is delaying us on finalising the deliverable. We will seek to finalise it as soon as possible. This was a recommendation that was supported in principle.

Senator WATERS: Okay. That's great. Thank you. Why was it delayed to go to health ministers? What was the issue upon which you sought further stakeholder consultation?

Ms Clancy: I would need to take that on notice.

Senator WATERS: Thank you for doing so. Another recommendation was that the department work with state governments to review the effectiveness of programs providing free period products. Some states are doing better than others in that regard. Is that happening? Are you working with the states on free period products? I have a separate question about the period products that the NACCHOs have been funded to deliver.

Ms Clancy: Yes. We are engaging with the states and territories to gain an understanding of the various measures that they have undertaken to address period poverty in their jurisdictions.

Senator WATERS: Okay. You are engaging with them to see what they're doing. What is the Commonwealth going to do?

Ms Clancy: I will just turn to a different page so I can give you information on that.

Dr Develin: You would be aware of the announcement of the government partnership with NACCHO for remote communities?

Senator WATERS: Yes. That's my second question. I'm not quite there yet, thank you, Ms Develin.

Ms Clancy: I was going to turn to the NACCHO one. That is what we have been doing already.

Senator WATERS: That's the extent of your activity. You're not going to do anything to supplement the states, because you are reviewing the adequacy of the state programs. Is there an intention if you find gaps, which I think there are, for the Commonwealth to address those gaps?

Ms Clancy: We're working through the analysis to understand the size and complexity et cetera. It would be a decision of government whether it will be addressed.

Senator WATERS: Is there a commitment from government to address any gaps in period programs?

Senator McCarthy: I'll certainly take that question on notice with regard to right across Australia, Senator Waters. We've certainly made a commitment with regard to NACCHO and the Aboriginal medical services and their relationship with First Nations clients.

Senator WATERS: Thank you. I will come to that now. How many NACCHOs are participating in that program? How many facilities in communities are getting access to free period products?

Ms Clancy: NACCHO is engaged. A grant agreement was executed in February. NACCHO has been scoping out and understanding what kind of products are offered, types, costs, stocks and other products across the country. They've engaged with 113 ACCHOs through this process in MM3 to MM7. They've engaged with some of the other NGO programs that are delivering free period products. They have selected a provider for an initial three-month period to test the logistics et cetera. That will be rolled out to seven starter sites. We expect that will start shortly.

Senator WATERS: Why just seven?

Ms Clancy: They want to test first before rolling out more broadly. It is a complex piece of work to deliver.

Senator WATERS: Thank you. Is there an intention to roll them out to all First Nations communities once you find a model that works?

Ms Clancy: They need to test the model and come back-—NACCHO is doing this work for us-—with an understanding of where the need lies as well. So it's a combination of a model and a need that overlap.

Senator WATERS: Minister, is there a commitment from government to meet the need?

Senator McCarthy: I will jump in on that one, Senator Waters. I'm certainly watching where we're going in terms of this policy in rolling out the period products with NACCHO and the model. At the same time, we're rolling out food security and 30 essential items across 152 stores. We've reached about 102 stores in remote Australia so far. So those 30 essential items don't include the free period products at the moment.

Senator WATERS: They might though? They could?

Senator McCarthy: That's right. I am watching this very closely. Clearly, we want to be able to do it. I am mindful that NACCHO will be able to give us some solid advice as to how they are going with rolling it out.

Senator WATERS: Thank you. I will move on now back to perimenopause and menopause matters. Firstly, the women's health advisory council was tasked by the inquiry and the government's response to look at particular matters. Firstly, is there a work plan for the women's health advisory council? Is that available anywhere publicly? If not, can you table that work plan?

Ms Clancy: Yes. There is a work plan for the women's health advisory council. I believe it would be on the website. I will check for you. If not, I will table it here.

Senator WATERS: Thank you very much. One of the recommendations of that menopause inquiry was that the women's health advisory council work with states and territories to develop a menopause action plan. Has council discussed that or has anything been done on that one?

Ms Clancy: Again, I want to check the number of that one and go through it. The committee recommends that the Australian government task the National Women's Health Advisory Council to assist state and territory governments to deliver a national menopause action plan which addresses best practice. That was supported in principle. The council is currently working. It is not part of its 2025 work plan. The council's term ends at the end of this year. The consideration of the next term and what might be on that is yet to come.

Senator WATERS: Okay. What is the mechanism? Presumably it will if the government has accepted it in principle. How do we make sure that happens? Forgive my ignorance. I don't know about those processes.

Dr Develin: The Women's Health Advisory Council obviously is made up of sector representatives and is chaired by the minister. In a way, it kind of has no capacity to direct states and territories. It really is an advisory to the Commonwealth government. I suggest that most of their advice has been very informative to the women's health budget packages that we've had through two successive budgets now. I think that has been the focus of their efforts as opposed to sort of coordinating or directing states and territories. They have, however, had a role in the national women's health strategy and, if you like, the report that has been collated around that. That is a collective effort of the states and territories in terms of women's health and the national strategy. The advisory committee has had a role in shaping the measurement of the progress of the national women's health strategy but also the report that has been recently released. That has been their mechanism in terms of working with the states and territories. We do work with the states and territories to report on the measures in the national women's health strategy.

Senator WATERS: Thank you. The government's response to the inquiry also suggested that the women's health advisory council talk with the Australian Medical Council and the medical deans to include-—it is recommendation 23-—actual education for folk studying to be doctors and nurses about women's health and, in particular, perimenopause and menopause. In some cases, they get one hour, which is outrageous sexism. Have you been directed to undertake that work to encourage the council and the deans to update their curricula to bring it into this century?

Dr Develin: In the last term of the government, the former minister, Assistant Minister Carney, actually met with the deans. We would have to go back. These were certainly the sort of issues. She was very keen to raise them personally. We would have to go back to that meeting. That was kind of the government's efforts in terms of the minister personally working with the deans to advance that.

Senator WATERS: So one meeting. Do you know if the new assistant minister for women's health, if that's the right terminology-—Ms Carney's replacement-—has taken that issue up as well?

Dr Develin: I'm not aware of that, but we would need to check with her office.

Senator WATERS: Thank you. The August communique of the council refers to an update on the development of a contraception decision support tool. I understand that's the budget allocation to support some kind of decision-making tree. Can I have a bit of information on who is doing that tool; where it is up to; and whether that tool will also include information about the barriers to accessing contraception and the cost of contraception?

Ms Clancy: The policy parameters for the tool are largely complete. They were developed within government working with a wide range of stakeholders through consultation, including the women's council. Healthdirect are building the tool. They have started the process of user design for that. We expect to have a tool early next year.

Senator WATERS: So it will be able to be used by people early next year?

Ms Clancy: That is our expectation. Correct.

Senator WATERS: There was a Medical Research Future Fund grant for an Australian perimenopause and menopause study, which I welcome. I will put some questions on notice about that. A proposal researching the impacts of peri and meno on First Nations women didn't get funding. What is the government doing to address the lack of targeted peer reviewed research on First Nations women's experience of perimenopause and menopause, particularly research that is actually led by First Nations women?

Dr Develin: I think we would need our colleagues in the MRFF and the NHMRC to help you with that in terms of their programs.

Senator WATERS: I'm happy for them to take their bit on notice. Given that nothing is actually happening under their auspices, my question is: what is the government and the department doing, given the lack of support so far?

Dr Develin: As you would appreciate, the Commonwealth's largest investments in health and medical research are both through the NHMRC and the MRFF, so any direction of efforts are through those two programs.

Senator WATERS: Since they haven't funded any, what is the government doing about that? Maybe that's a question for the minister. Will you now intervene?

CHAIR: Senator Waters, that will be your last question. I need to share the call.

Senator McCarthy: Senator Waters, I can take that question on notice for you.

Senator WATERS: Can I put one more on notice, quickly, Chair?

CHAIR: Just quickly.

Senator WATERS: This is to the TGA and relates to our earlier discussion. Could you let me know on notice, please, whether since 2005 any pharma companies applied to the TGA to bring their MHT patches to Australia? Thank you.

Senator RUSTON: I want to ask some questions about the CDC or the proposed CDC. Maybe I will go to you, Professor Kidd. What did the CMO actually do during the COVID pandemic, particularly in relation to the powers under the Biosecurity Act?

Prof. Kidd: Can you repeat that?

Senator RUSTON: What did the CMO actually do during the COVID pandemic, with particular reference to the Biosecurity Act?

Prof. Kidd: I may just go back to the question you asked before. I have advice that there were 75 instruments for COVID-19 made by the department under the Biosecurity Act 2015. Under each of these instruments, powers would have been used a variable number of times. We can provide further details on how the act worked, if you wish.

Senator RUSTON: Were any of those 75 instruments issued during the time that you were acting as the CMO?

Prof. Kidd: I had only very brief periods as acting CMO. I don't recall being involved in any of those particular instruments, but we would need to, again, take that on notice. It is five years ago.

Senator RUSTON: So you weren't acting at the time of the declaration in relation to Australians from India being prevented from coming back into the country?

Prof. Kidd: I will give you a bit of background to the Biosecurity Act. The Governor-General made the declaration on 18 March 2020. That was on the advice of then minister for health and aged care, who of course consulted with the CMO, the Australian Health Protection Committee at the time and with relevant colleagues in the government at the time.

Senator RUSTON: So the CMO makes a recommendation. What is the interplay is between the CMO and the Director-General of Biosecurity?

Prof. Kidd: At the moment, the Chief Medical Officer is the Director of Human Biosecurity.

Senator RUSTON: So the CMO is the Director-General of biosecurity. He makes a recommendation in relation to the use of these powers. He still then has ministerial discretion in relation to the exercising of those powers and then it goes to the Governor-General for the determination?

Prof. Kidd: That's correct.

Senator RUSTON: Thank you. Under the legislation that is currently before the parliament, who has the decision-making power with regard to public health and social measures, should we have a pandemic?

Mr Comley: I will ask Ms Wood to start this answer. She will answer. It's not as straightforward as that. There is a difference depending on the nature of the decision being exercised.

Senator RUSTON: So you are making it more complicated by this act?

Mr Comley: We'll allow Ms Wood to comment. Part of the CDC design is responding to the recommendations of the COVID-19 inquiry. One of the distinctions being drawn is that there are some decisions that you might describe as, without diminishing them, reasonably technical decisions on a medical and health basis. There are others that go to significant issues of whole-of-government or whole-of-society concerns in terms of the trade-offs that might be involved. That is really what the COVID-19 inquiry highlighted. The design that is proposed in the legislation tries to reflect the different nature of the decisions and, therefore, who is the appropriate decision-maker on that, where that decision-maker always should be informed by the best available health advice at the time. I will allow Ms Wood to expand on that.

Ms Wood: Thank you, Secretary. Senator, by and large, the powers that the parliament is considering are being distributed differently, so there's no expansion of powers, if you like.

Senator RUSTON: Maybe I should ask the question again so we can be really clear. I want to understand. Under this legislation, who has the decision-making power? Maybe you could explain what changes to decision-making powers occur under this legislation in relation to public health measures during a pandemic?

Ms Wood: In relation to the Biosecurity Act in particular?

Senator RUSTON: Well, in relation to the Biosecurity Act. More generally, what I'm really concerned about is that we have this enormous great organisation about to be created and we really can't follow where the powers are going. How many people have powers under the new act?

Ms Wood: I'm happy to take that question. There are two bills, as you know, Senator, that are before the parliament. They transfer responsibilities and some powers of the Commonwealth Chief Medical Officer to the proposed Director-General of the CDC. In relation to the Biosecurity Act, there's some powers that are proposed to transfer to the Director-General that reflect their discrete public health functions in the Commonwealth. As you would appreciate, a new statutory agency comes with different functions and responsibilities that are designed in ways to be distinct from the Chief Medical Officer, whose role has changed somewhat since the pandemic.

Senator RUSTON: I am particularly keen to understand. There seems to be a transference of powers to the secretary from the CMO that cannot be delegated. Could you explain to me what they are?

Ms Wood: The Director of Human Biosecurity is the broad function that you are describing. That has been split into different responsibilities. The key current decision-making powers of the Director of Human Biosecurity are in relation to determining listed human diseases. That is one of the powers that is proposed through the bills to transfer to the Director-General of the CDC.

Senator RUSTON: I just asked you about the ones that are being transferred to Mr Comley or whoever holds that position.

Ms Wood: Under the bills, the secretary will be the Director of Human Biosecurity in relation to each of the powers other than those two powers that are proposed to go to the Director-General of the CDC. I mentioned the first one, which is the list of human diseases. The second responsibility that is proposed through the bill is to transfer to the CDC responsibility for providing a human health risk statement, if required, by the department of agriculture.

Senator RUSTON: Professor Kidd, do you think that Australians would accept a declaration coming from the secretary as opposed to a declaration being informed by the highest medical officer in the land as being the appropriate place for these sorts of decisions to be made?

Prof. Kidd: We have a similar situation with the chief vet, where the responsibilities sit with the secretary of the department where she sits. My understanding is that this will mirror that arrangement, which works in that department. I might let the secretary speak, though, about the consultation that he might undertake when making decisions.

Senator RUSTON: That's fine. Mr Comley can obviously speak for himself. I am somewhat confused. What does this legislation seek to do that currently can't be done in terms of all this transference of powers, delegations and declarations? What are you trying to do here that you can't currently do?

Mr Comley: I might start at the principle level. The philosophy behind the CDC is that it has three elements to it-—independence, so it can make independent recommendations; expertise, so the expertise sits within a statutory body that is separate from the department of state; and generally advisory. That distinction between expert, independent and advisory and the operation of the department is to recognise that, in the exercise of many of these biosecurity functions, there is going to be a need to balance a range of considerations that go beyond straight health. As we saw during the pandemic, a decision to make certain health related directions had very significant economic consequences, triggered a range of other things at both state and Commonwealth levels. We're trying to achieve that distinction.

The CDC in the first instance will primarily concentrate on communicable diseases. Over time, it will also be independent, expert and advisory on non-communicable diseases to elevate public health at the Commonwealth level. Perhaps one thing is worth pointing out. In the design of the CDC, there were some people who advocated that the CDC should make decisions unilaterally and that they should have impact both on the whole of the Commonwealth and the states and territories. That's not the intention. The intention, again, is that the states and territories would still have responsibility for their public health powers. We're not fundamentally rewriting the arrangements between the Commonwealth and the states in the process. They would be informed by the independent expert advice of the CDC.

The intention is that the AHPC would still continue to be chaired by the Chief Medical Officer, and the DG of the CDC would be on that AHPC as well. So we're trying to have a centre of expertise that can be independent and be seen to be independent. It can in some circumstances be in a position where it publishes an advice that could be informing the commission. It is also advising-—

Senator RUSTON: Mr Comley, we are really short on time. What is that body going to do that you can't currently do now?

Mr Comley: Well, I will come back to this independent, expert and advisory. Ms Wood might want to comment. Apart from being a centre of expertise on public health, it is the sense of how at times people really want independent statutory advice available. It informs decision-making that has to by its nature take account of a broader set of considerations when forming a final judgement.

Senator RUSTON: You just referred to it as a centre of excellence on public health.

Mr Comley: Independent expertise on public health, including communicable and ultimately non-communicable diseases.

Senator RUSTON: So this has actually expanded out to be something a lot bigger than the original intention of being a centre for disease control that enables Australia to maximise its preparedness for another pandemic. That doesn't seem to be what it is any more.

Mr Comley: I can't comment on exactly who you might be referring to with regard to expectations of what it would do. I would say that in terms of the vast majority of stakeholders that we deal with, they always envisage the CDC to have a remit that is beyond just communicable diseases and goes to non-communicable diseases. In fact, if we've had any criticism, it's because of the staging of the approach and a desire to have more work on non-communicable diseases. I don't know if Professor Kidd would like to comment.

Senator RUSTON: What activities of the department will be transferred to this? Out of all the people and all the organisations that currently do various things, including yourself, Professor Kidd, which of those functions are going to be transferred into this CDC, including from your own department, Mr Comley?

Mr Comley: I will ask Ms Wood to comment. I note that there's a separate thing. I restructured the department not motivated by the CDC but with the idea of having the CMO have a role as the Chief Medical Officer without the need to run a group. Ms Wood is running the group that used to be run by the CMO. A significant number of those functions are transferring into the CDC. Maybe you would like to list them, Ms Wood.

Ms Wood: Thank you, Secretary. To directly answer your question, Senator, in relation to what powers are to be conferred to the CDC from existing legislation, there are three acts.

Senator RUSTON: I know all that. That's all in the EM.

Ms Wood: In terms of the functions, as the secretary has indicated, the CDC will be progressively implemented, with an initial focus on communicable diseases, strengthening pandemic preparedness, as you've

indicated, environmental health, climate change and other areas of public health risk, such as antimicrobial resistance.

Senator RUSTON: Yes.

Ms Wood: A lot of those functions are-—

Senator RUSTON: Currently in the department?

Ms Wood: That's right. The anticipation is that they will be mogged out to the CDC. Numbers of staff who would be transferred haven't been decided in granular terms. On the whole, we're expecting something in the order of 200 or so people who are currently in the department to move to a statutory agency if the bills are passed in their current form.

Senator RUSTON: So 200 people will be mogged out of the agency into the CDC. Is that all the staff, the ASL, the CDC will have, or will there be more than that?

Ms Wood: No. It's envisaged to grow over time to the order of 250 or 260 people. The exact number will depend on a couple of things, obviously, including the seniority of technical skills and the expenses of the additional skill set that the Director-General, once he or she is appointed, will want to bring in. It will also be a little determined by the strategic-—

Senator RUSTON: She will want to bring in?

Ms Wood: As in new recruitment.

Senator RUSTON: You just said she will want to bring in.

Mr Comley: He or she.

Ms Wood: He or she, sorry.

Senator RUSTON: Sorry, you just said 'she'.

Mr Comley: No. She said 'he or she'.

Ms Wood: My apologies. I intended to say 'he or she'.

Mr Comley: We haven't determined the person. I think that's what she's alluding to.

Senator RUSTON: I'm interested to understand what the need or the rationale is. Ms Wood, you were talking about the acts that are seeking to be changed by the transition and consequential provisions act that include amendments to the FOI Act that apply specifically and only to the CDC. I'm interested to understand why it is believed that the FOI Act, in its current form, is insufficient to be able to deal with this.

Ms Wood: I'm happy to answer that at a high level. Mr Madden might have some further information to add. The consequential and transitional bill, the second of the bills before the parliament, amends the FOI Act essentially to ensure protected personal and commercial information won't be disclosed—so it's consistent with other FOI principles.

Senator RUSTON: Why do you need this provision, and what is the insufficiency in the current FOI Act that you are seeking to remedy? The changes to the FOI Act are quite substantial.

Ms Wood: The changes just reflect a new data rating that's proposed for the CDC. There are some reasonably significant additions through the creation of a proposed public health network that are manifest in the data provisions in the bill. With that come some consequential amendments to the FOI Act. It's not changed; it's just consequential rather than substantive amendments.

CHAIR: Senator Ruston, it is now one o'clock. I've always prided my career on never standing between a room full of people and food. Can I get a sense of how much longer you need to wrap up this block.

Senator RUSTON: I'd prefer to come back, if that's easier.

CHAIR: The hungry bunch will probably agree with you.

Senator McCarthy: Chair, for Senator Waters, I want to clarify that the period products aren't on the 30 essential items until we see the model of NACCHOs so that they can be part of the free period products.

CHAIR: Thank you for noting that for the *Hansard*.

Senator RUSTON: Before we go to lunch: have you had any opportunity to get me that timeline in relation to the Medicare website?

CHAIR: Can we seek to have that from officials before the end of outcome 1 this afternoon, Mr Comley?

Mr Comley: We'll do our best. It's very hard for me to commit. I haven't seen any of the material. I don't know how hard it is to extract.

CHAIR: Great. We'll endeavour to do that. Thank you for the reminder, Senator Ruston.

Proceedings suspended from 13:02 to 14:01

CHAIR: We will reconvene. We are still in continuation of outcome 1.

Senator ROBERTS: I have questions for the TGA.

CHAIR: The secretary wants to correct the record.

Mr Comley: The TGA will come to the table. In evidence that Ms Clancy provided to Senator Waters, she asked about the timing of the design of a contraceptive decision support tool. Ms Clancy said that it would be available from January. In fact, the bill will commence in January. It will be available from mid-year. I want to make sure that is on the *Hansard* so that we correct that piece of evidence.

CHAIR: Excellent. We will draw Senator Waters's attention to that.

Senator ROBERTS: Thank you for being here again, especially Professor Lawler. Before I start, can we deal with a statement I hear on the internet all the time—that you get more aluminium in your food than you do in vaccines. Aluminium in food is ingested at 0.3 per cent. In vaccines, it's ingested at 100 per cent. Individual results may vary. Is this a fair statement?

Prof. Lawler: I'm not sure where you're seeing that. I don't have the information you're referencing in front of me.

Senator ROBERTS: I'm asking you whether it's accurate.

Prof. Lawler: I'm not sure that is necessarily a question for the TGA to respond to. We can provide you with information on the process that we undertake in terms of the evaluation and authorisation of therapeutic goods, including vaccines. Is this a claim that the TGA has made?

Senator ROBERTS: No. That's my understanding. What is the TGA's recommended maximum daily intake of aluminium for a child aged six months, please?

Prof. Lawler: By mouth as a recommended daily intake?

Senator ROBERTS: Yes.

Prof. Lawler: I don't believe that the TGA sets a recommended daily ingestion of aluminium, Senator.

Senator ROBERTS: What is the daily maximum for a child of six months that can ingest aluminium in food?

Prof. Lawler: I would suggest that those are probably questions best posed to Food Standards Australia New Zealand, Senator.

Senator ROBERTS: The US Food and Drug Administration recommends exposure of five micrograms per kilogram in infants. At six months, the average weight of an infant is seven kilograms, making the maximum daily exposure 35 micrograms. The Infanrix hexa vaccine contains 825 micrograms of aluminium per dose, which is 24 times its safe daily limit. Do you accept injecting children at 23 times the safe level? Do you accept that this unsafe aluminium exposure is a contributing factor to aluminium derived autism?

Prof. Lawler: I will throw to Dr Dascombe in a moment. I will answer a couple of the things there in reverse order, if I may. The first is that, in answer to your second question, no. I don't believe that there is a recognised regulator—I'm happy to be corrected—that does.

Senator ROBERTS: Rather than relying on someone else, do you have any data or research?

Prof. Lawler: I'm just trying to answer your question. I don't believe that there is another regulator. I'm just using that as back-up. We have seen no credible safety signal that aluminium load either in single or scheduled immunisation delivery is a contributor to autism. The second thing I would say is that I am not sure this is the forum, nor do we have the time, to clarify the distinction between injected and ingested aluminium. They are quite different biomechanical processes. I don't think the two are comparable. I will ask Dr Dascombe to add to that answer.

Dr Dascombe: I echo the comments of Professor Lawler. Neither the TGA nor any international regulator has detected or confirmed any safety signals relating to any vaccine and autism. This is also supported by the weight of scientific evidence.

Senator ROBERTS: What is the TGA guidance for the injection of multiple vaccines into a six-month-old at the same time causing amplified aluminium? Each of those doses has aluminium adjuvant, a preservative, so each of them is 24 times the daily safe limit.

Prof. Lawler: My apologies for breaking in, Senator. There are a couple of points on that. It is not the practice or the role of the TGA to make recommendations on immunisation schedules. That sits within the province of

ATAGI, the Australian Technical Advisory Group on Immunisation. I would also highlight that we have frequently responded to questions around the aluminium load in the vaccination schedule and their consequences. Most recently, but perhaps more recently, is a Senate question on notice 24-003075. We have discussed it in this place a number of times.

Senator ROBERTS: You see the problem. Just one vaccine can be 24 times over the safe daily limit. You are recommending injecting multiple of them at the same time. These infants could be getting over 100 times the safe limit and you just keep on injecting them right in there and then claim aluminium poisoning isn't the reason they come down with autism in some cases the very next day. How can you justify this?

Prof. Lawler: I will answer those questions in reverse order, if I may. I will answer the second. There is no indication that the vaccination schedule is linked to autism. Indeed, it has been highlighted not just today but previously. There's no credible evidence that there is a linkage between vaccination and autism. As I just indicated in my previous answer, it is not the role of the TGA to recommend vaccinations. We assess them for safety, quality and efficacy. It's the role of ATAGI to recommend the vaccination schedules.

Senator ROBERTS: Why don't you tell the pharma companies to reduce the aluminium preservatives down to safe levels so you can get parents to trust your vaccine again and the parents can trust your advice again?

Prof. Lawler: There are a couple of elements in your question. We evaluate the submissions from sponsors and evaluate the process of manufacture and quality control to ensure that the balance of risk versus benefit is appropriate. That is a determination that we make not only in the authorisation but also in the post-market monitoring through our pharmacovigilance of any therapeutic good with the inclusion of vaccines. In terms of trust, we recognise that there is an active campaign to undermine the trust of regulators, the TGA particularly. We undertake to restore or bolster the trust of the public, which I have to say was during the pandemic and is still, despite some narratives, at a high level. We seek to do that through education and guidance. We do that through being very clear and transparent about what we do and by addressing dis- and misinformation when and if it occurs.

Senator ROBERTS: How many vaccines in the Australian schedule have been subject to a gold standard trial, meaning specifically a randomised double blind placebo control study where the placebo is saline and not another vaccine?

Prof. Lawler: I recognise that you weren't here before lunch. We had a conversation with Senator Antic regarding the use of the term 'gold standard'. We recognise that the use of a placebo control randomised double control trial—there are a number of different terminologies used—is of a very high standard and presents robust and dependable evidence. The challenge, of course, is whether something constitutes a gold standard in the way that you have used it. It actually very much depends on context. We use controlled or blinded trials or placebo trials when we are interested in determining the difference between a control arm and an intervention arm. This is really effective when we're looking at incremental improvements in therapies or when we're looking at the introduction of new therapies. The challenge we have, of course, is that when there is an established therapy that has been shown over decades using both documented and real-world evidence to be both safe and effective, it is ethically questionable—and, in some instances, ethically indefensible—to use a placebo in that non-intervention arm.

I will give you two examples, if I may. We have vaccine preventable diseases, and we have a very clear demonstration of reduction in not only mortality but morbidity in those diseases. Let's choose polio and small pox, diseases that have had a specific impact for many decades and have led to untold suffering. One of them has been eradicated by the use of vaccines and one of them has been virtually eradicated. If we were to introduce placebo controlled trials for those drugs, that would be horrendously unethical. We would be essentially and knowingly infecting children with a disease that could kill, paralyse or maim when we know that there is a way of preventing that. That's not ethically defensible.

Senator ROBERTS: What you are saying is that there has been no double blind placebo control study where the placebo was saline and not another vaccine?

Prof. Lawler: No. What I am saying is that would not be an appropriate approach to be taking today with the vaccines we use.

Senator ROBERTS: Has it been taken in the past?

Prof. Lawler: I also would highlight that the introduction of vaccines occurred some time ago. And also—

Senator ROBERTS: So it has not been done?

Prof. Lawler: I will let you finish.

Senator ROBERTS: So it has not been done, then, the tests?

Prof. Lawler: Whether these—

Senator ROBERTS: A double blind trial?

Prof. Lawler: Well, we've actually already taken on notice to provide concrete evidence on which of those vaccines has been subjected previously to blinded control trials.

Senator ROBERTS: How many COVID vaccines have been destroyed because they aged out? What was the purchase cost for those products?

Prof. Lawler: Dr Anna Peatt from the national immunisation division will respond to that.

CHAIR: This is your last question, Senator Roberts.

Dr Peatt: Senator, could you please repeat the question? I didn't quite hear it.

Senator ROBERTS: Certainly. How many COVID vaccines have been destroyed because they aged out? What was the purchase cost for those products?

Dr Peatt: Senator, I would have to take that question on notice. I don't have that available with me today.

Senator ROBERTS: Was close to 35 per cent of the multibillion-dollar COVID vaccine supply binned or trashed?

Dr Peatt: I would have to take that question on notice.

Senator ROBERTS: I am asking for you specifically to tell us whether or not it was 35 per cent.

Dr Peatt: I don't have that figure in front of me.

Senator ROBERTS: I am asking for you to just say what the figures are. Can you confirm that is 35 per cent of what we bought?

Dr Peatt: Yes, I can do.

Senator RUSTON: I will go back to the CDC. What foreign CDC would you say that the model that is being proposed by this legislation is most closely aligned with?

Ms Wood: Senator, do you mind repeating the question? What forum, did you say?

Senator RUSTON: What foreign CDC would you say that the model proposed by this legislation is most closely aligned to?

Ms Wood: Look, we took features from different models, recognising the federated responsibilities in Australia and the design features that the secretary described earlier, including that we're not seeking to change the roles and responsibilities within the federation. So the Director-General's duties and responsibilities are additional. They essentially add Commonwealth investment and further clarity to the purpose and nature of public health advice. It doesn't change any roles and responsibilities with regard to the states and territories.

Senator RUSTON: I didn't ask that. I asked you if it was aligned to any international model. Did you consult with any overseas officials representing foreign CDCs in the development of this model?

Ms Grinbergs: I will add to Ms Wood's comments. As we were designing the model for an Australian CDC—as Ms Wood has indicated, the model and the design are very much in the Australian context—we did look at a range of different public health institutes globally. The European Centre for Disease Prevention and Control, which is primarily an advisory mechanism—

Senator RUSTON: Just to be really clear, you said you 'looked at', but did you consult with officials from these agencies?

Ms Grinbergs: Yes, we did.

Senator RUSTON: Okay. That was my question—whether you consulted with them. In the process of consulting them, you have not based your CDC or the proposed CDC on any particular model that you've seen somewhere else in the world that you believe was working well?

Ms Grinbergs: Not explicitly, because it had to be framed in the Australian context.

Senator RUSTON: Okay. I'll just go back to the roles and responsibilities, particularly in relation to the transfer of the roles and responsibilities to the department. In your explanatory memorandum, it says: 'The role of the Commonwealth Chief Medical Officer in the department regarding health protection will change following the commencement of the Australian CDC and the establishment of the Director-General. As a result, the role of the Director of Human Biosecurity will be transferred from the Commonwealth Chief Medical Officer to the department's secretary.' I just want to be really clear and understand, from all of you, who within the health

system is the ultimate decision-maker in a pandemic. Is it you, Mr Comley, in your role as secretary? Is it you, Professor Kidd, or is it the new Director-General of the CDC? Where does the ultimate buck stop?

Mr Comley: I'll ask Ms Wood or Ms Grinbergs to comment further. I think the ultimate decision-maker for most of the key decisions will be the cabinet, for most of the key decisions, on advice.

Senator RUSTON: I assume within the health system.

Mr Comley: Well—

Senator RUSTON: Who, ultimately, is the one who signs their name on the recommendation? As you say, ultimately, the government can decide what it wishes to do or not do. Who is the health professional who signs off on the health advice? In your instance, you cannot assign your power to someone else for the human health response side as an example. So is it you, Mr Comley?

Mr Comley: If we're talking at the official level and we're excluding the items that Ms Wood already indicated were reserved for the DG of the CDC, the secretary of the department would be the most senior official making a recommendation on a biosecurity or a health matter in a pandemic.

Senator RUSTON: Just on that, I'm trying to understand—

Ms Wood: That's right. There were no changes to the power or the decision-maker. There's simply a transfer of two existing powers to the Director-General and a transfer of the balance of those powers that currently reside with the Director of Human Biosecurity to the secretary.

Senator RUSTON: You're making it sound very much like there is actually nothing to see here. But it quite clearly states in your EM that all the powers that are currently vested in Professor Kidd are now moved to you. There are some of those powers that are now moved to you that you aren't able to delegate, including some quite significant powers in the time of a pandemic under the Biosecurity Act. I'm just interested to understand what the decision-making process was to suggest that you—with the greatest amount of respect, from your CV, you don't look like you're a health official or have any health or medical experience, whereas Professor Kidd obviously does. We've transferred his responsibility to you, and yet you are not the medical expert. So I am just interested. That is clearly the case—that all of your powers, as they currently exist and according to your explanatory memorandum, have gone from Professor Kidd to you. What's left, in terms of responsibility, for the Chief Medical Officer when it comes to a pandemic?

Mr Comley: There's a significant responsibility for Chief Medical Officer because obviously someone—whoever might be in my position—would not make a decision of that type without advice. In the same way, across any large department there are pockets of expertise that are not held by an individual secretary, and so you have to receive advice. In fact, in the example we provided—the one we were talking about before in terms of communications—people are providing certifications on legal matters. They're providing certifications from a comms perspective. In a current program we have, in which I am from time to time a decision-maker, which is the Medical Treatment Overseas Program, the secretary is the decision-maker. The secretary takes advice, including from the Chief Medical Officer, on the clinical matters. But some decisions are not purely clinical decisions or purely medical decisions, and that's the role of integrating that within the secretary of the department.

Senator RUSTON: What's the problem you're trying to solve by taking the powers away from the CMO?

Mr Comley: Well, when I describe it as a problem, I think I made reference earlier to the COVID-19 inquiry—the one headed by Robyn Kruk. It made a number of recommendations and observations that went to the question of how genuine whole-of-government decision-making was made in a pandemic and made it clear that certain decisions are not purely clinical decisions that needed to be located within a body or a person; they took into account a broader range of considerations. That is essentially what is trying to be addressed in this matter. That's why the powers that will be moved to the DG of the CDC are what I might describe as the more narrow and technical questions. And then the questions that come to broader decision-making on behalf of the balance of considerations across society sit with the secretary. Obviously, in practice, the closer a decision looks like it is a straight clinical decision or relies on medical advice then the advice of the CMO would be more and more—it's not whether it's definitive or technically persuasive in terms of determining the outcomes. But, where you move to a point where you're making a significant decision that has broader conversations or a significant recommendation to a minister or cabinet, the idea is to integrate that within the secretary of the department. As Professor Kidd said, that is the model that currently exists on the agricultural side of government, where you could have a secretary of agriculture who is not a technical expert but takes technical advice to form judgments about animal health and security.

Senator RUSTON: So, clearly, this whole act makes you the Chief Pooh-Bah when it comes to the ultimate decision; they're basically saying the buck stops with you. I'm interested to follow up on the FOI and, once again,

your memorandum of understanding. In there, it says that there is a set of information that must not be published. We're not saying you don't have to publish or you've got means to claim why you wouldn't publish. You must not publish. You refer to the exemptions of things that cannot be published under the Freedom of Information Act as publications that will apply to matters affecting national security; matters that risk harming population groups; and the one I'd like to bring to your attention, which is the integrity of other government processes. That sounds to me like a very big catch-all for anything that the government would not want to release. They will just say that it is the integrity of other government processes. Why is that necessary? Why wouldn't you rely on the existing processes that allow for Australia to have some level of confidence in transparency—although I know that we are seeking to change the Freedom of Information Act, as we sit here at the moment, to make it less transparent. But why would you need to have that as a 'must not publish' provision in the FOI process?

Mr Comley: I'll pass to Ms Wood or Mr Madden.

Ms Wood: I might perhaps start and I'll pass to Mr Madden to add to it. One of the design principles of the CDC—the rationale or the benefits, if you like, that will accrue if the CDC is to be created—is new publication and transparency requirements that are explicitly designed to reflect the legislation to increase the understanding of the community about the basis of public health advice. One of the observations that the COVID reviewers made—

Senator RUSTON: With the greatest amount of respect, I was asking why you needed to have a catch-all provision. I'm not asking you to explain all the reasons around the FOI. There is a specific requirement in here that says, 'You must not publish'—and then there's everything in the interim—and the final is 'integrity of other government processes'. I'm keen to understand why you felt the need to have a catch-all of that size as a change in this act.

Mr Madden: Within the legislation, as Ms Wood was stepping through, there are requirements for the CDC to publish its public health advice. There are then exemptions and things which are considered exempt material, and that's defined in the legislation. The exemptions mirror exemptions that already exist under the Freedom of Information Act. We specifically refer to the sections of the FOI Act that would ordinarily offer protection from the release of information under FOI requests.

Senator RUSTON: So why do we repeat them? Why don't you just use the Freedom of Information Act?

Mr Madden: Under the Freedom of Information Act, the CDC would be subject to FOI requests. As an Australian government agency, the FOI Act still applies. In addition to that, we are introducing a duty for the Director-General to publish all advice that it provides to governments. That includes a recommendation, and that is provided in writing.

Senator RUSTON: I'm not asking about what you are publishing. I'm asking you what you are explicitly saying in your act you are not publishing. I'm happy for you to have to think about this because the bill will come to the Senate and you can have much more fun with me there—well, the minister will, when we go through it. But I'm just keen to get some more clarity because, if you read your explanatory memorandum, it sounds like you've just given every piece of responsibility to the secretary, and you've just taken a whole chunk and said, 'We're not going to publish anything,' or, 'We're not going to provide information because of the Freedom of Information Act changes.'

Mr Madden: Yes. It creates a positive duty to publish. Anything that they provide must be published unless it meets the threshold of being considered exempt material.

Senator RUSTON: And that exempt material—

Mr Madden: Then the exempt material includes those specific references to things which would otherwise be exempt under the FOI Act.

Senator RUSTON: Which is a catch-all for any government process. We will prosecute this further, but you can probably see here that I'm very concerned about the transference of powers and who gets what in terms of this. I'm also very concerned about the lack of transparency that appears to be apparent by the EM. So, on notice, for when you come to the Senate, those questions will be asked. Could I now go to the National Health Reform Agreement. Is the government still committed to the agreement that was struck at the National Cabinet in December 2023, where the government committed to the Commonwealth increasing the National Health Reform Agreement contribution to 45 per cent over a maximum of a 10-year glide path and, from 1 July 2025, with an achievement of 42.5 per cent before 2030?

Senator McCarthy: That's correct. We did agree to that in December 2023, and we certainly are continuing the work with the states and territories in terms of the recent gathering of ministers in September with the health

minister. We do want to maintain this current situation but also improve in terms of the total Commonwealth contribution to state-run public hospitals.

Mr Comley: Can I just add something there?

Senator RUSTON: Could I just finish with the minister, and then, of course, you can, Mr Comley. There was a commitment in the communique following the meeting in December 2023, and I read out verbatim what the commitment was. I'm just seeking to understand whether the government's commitment to providing an achievement of 42.5 per cent by 2030 remains the government's commitment.

Senator McCarthy: I certainly have that the National Cabinet agreed in December 2023 that 42.5 per cent and 45 per cent was subject to a cap on Commonwealth contributions.

Mr Comley: That is the very important point, Senator. I know that some parties to these negotiations represent at times that there was an unconditional commitment to 42.5 and 45 per cent, but it was always subject to annual funding caps and that if those annual funding caps were met then it was possible that the 42.5 or the 45 per cent would not be delivered, but the total funding caps that were committed by the Commonwealth would be delivered. So, from the Commonwealth's perspective, there has been no backing away from the substance of the agreement that was entered into by National Cabinet in December 2023.

Senator RUSTON: So in December 2023—the second paragraph or the next paragraph after that said:

National Cabinet endorsed the current 6.5 per cent funding cap being replaced by a more generous approach that applies a cumulative cap over the period 2025-2030 and this includes a first-year catch-up growth premium …

What was that more generous approach? Clearly, they've moved away from the 6.5 per cent to a more generous approach. Also, in the agreement, it doesn't say 'conditional on it', by the way, which is what you just said. That is not reflected in the communique that I have before me.

Mr Comley: Definitely, the agreement at the time was that the caps—and without being deliberate about it, the language 'cap' is what is there as a cap on the Commonwealth contribution. The agreement that was struck in December 2023 was that the first-year catch-up would be 13 per cent, and then subsequent years would be a cap of eight per cent growth per year as the cap—so moving from a pre-Nat Cab agreement of 6.5 per cent cap to 13 per cent in the first year and eight per cent each subsequent year. Obviously, the implication of that—

Senator RUSTON: Where's that now? The communique from 2023 does not say—

Mr Comley: Not all things that are included in Commonwealth state agreements necessarily are in the communique, but they can be in other forms of documentation between states and territories. But the agreement was at the time to be subject to the Commonwealth contribution caps of 13 per cent and eight per cent in each subsequent year.

Senator RUSTON: Can I just clarify what you said at the start of your contribution here. Have you just said that the federal government may not reach 42.5 per cent by 2030? In fact, you're making it sound like they won't reach 42.5 per cent by 2030. Are you telling me that the commitment that is in this communique is not going to be able to be achieved?

Mr Comley: No, I'm not saying that. What I'm saying is that what's known as the Commonwealth contribution rate will depend on what happens over the next 5½ years. So if, for example, there were hospital expenditure growth in one year of 20 per cent—

Senator RUSTON: I totally understand that—

Mr Comley: Well, I think it's very important—

Senator RUSTON: But I'm just keen to understand—

CHAIR: Can we just let the official answer the rest of the question that you're asking because I think this is an important point.

Senator RUSTON: Sure. There was a public commitment of 42.5 per cent by 2030. It was not conditional when it was announced in the press releases that I've got here. It was basically a big fanfare—42.5 per cent by 2030 and 45 per cent by 2035. In that public promise, there was no mention apart from that they were going to be more generous around the 6.5 per cent cap. That was the only thing that was mentioned in any of the media that I have seen. Will the government commit to 42.5 per cent by 2030 or not?

Mr Comley: There are a couple of points here. The first is that the Commonwealth has recommenced negotiations with the states on this. The states haven't agreed to any final agreement, so that negotiation is still ongoing. While the intention is to conclude that negotiation by December this year, that negotiation hasn't continued. States and territories and the Commonwealth are still negotiating parts of that agreement. The

Commonwealth's intention is still to meet and to be able to be in a position that the CCR can be increased. The extent of increase depends on the growth in hospital price and volume growth. The Commonwealth has always, and the agreement at Nat Cab in 2023 was, that it would be subject to a cap from the Commonwealth.

Senator RUSTON: Minister, is the government walking away from its 42.5 per cent commitment for its federal contribution for hospital—

Senator McCarthy: I do believe that the secretary has answered your question.

Senator RUSTON: I'm not asking the secretary; I'm asking you, the government. The secretary can speak on behalf of the department. Only you can speak on behalf of the government.

Senator McCarthy: I've given you my response in terms of Minister Butler's dedication to working with the states and territories in terms of reaching an agreement, and I will certainly continue to say that.

Senator RUSTON: Just so we're really clear, is the government still committed—

Senator McCarthy: I've answered your question.

CHAIR: Thank you, Senator Ruston. I'm going to move the call to Senator Pocock.

Senator DAVID POCOCK: Thank you. I'm keen to pick up on these questions that Senator Ruston was asking. I'm not sure if any of you caught the interview with the ACT health minister on *RN Breakfast* on Monday, but I have some questions relating to that interview and the ACT. Minister Stephen-Smith said in her interview that, as it stands, with the funding put on the table by the Commonwealth so far, the ACT won't be reaching 42.5 per cent by 2030 as agreed by the National Cabinet. I've also gone back and looked at the communique and I have some questions based on that. What is the current Commonwealth contribution rate towards the ACT's hospitals?

Mr Comley: I'll just ask someone to have a look at that. But I would just reiterate my point that we're currently in negotiations with the states and territories. For any level of funding cap, the Commonwealth contribution depends on growth rates. Obviously, every—

Senator DAVID POCOCK: I've got some questions about that.

Mr Comley: Every party to the negotiation will have their own view or their own interest in putting forward what they think the growth rates are. The higher you put those growth rates forward, the lower the CCR would be.

Senator DAVID POCOCK: Sure. As a senator for the ACT, I'm sure you'll know that I have a certain view on this.

Ms Street: We actually don't have the CCR by state in front of us here. Is there a particular year you're interested in?

Senator DAVID POCOCK: The last year you've got available.

Ms Street: The last year that's available. If we can take that on notice, we can get that back to you.

Senator DAVID POCOCK: There are 40 people in this room and no-one has that figure? You had to have known that this would come up.

Ms Street: In terms of the funding that's in 2025-26, we've got those figures in front of us. We don't have a contribution rate in front of us.

Senator DAVID POCOCK: What's 2025-26?

Ms Street: In terms of the actual funding?

Mr Comley: Well, 2025-26, again, would only be a projection since that hasn't occurred. So I think we should actually get you the latest available CCR based on actual data.

Senator DAVID POCOCK: Okay. I'm very surprised that no-one in this room has that figure.

Ms Street: We will get that.

Senator DAVID POCOCK: Is that a concern for you, Secretary?

Mr Comley: It's not a concern. I'm not concerned that we don't have the number. We've been discussing that number with the states and territories. I must say I've looked in my briefing notes and I don't have that number with me, but we're happy to provide that as soon as possible. That won't be hard to get.

Senator DAVID POCOCK: How long are we talking? I've got 15 minutes here.

Mr Comley: I think the team is watching this—

Senator DAVID POCOCK: As in today or is it on notice? What are you—

Ms Street: Today.

Senator DAVID POCOCK: Okay.

CHAIR: I think the practice has been since this morning, Senator Pocock, that we would attempt to get them by the end of the outcome area if not later on today. I think that was the commitment by the secretary from memory. If we could work on that, that would be appreciated.

Senator DAVID POCOCK: Just to be clear, from what I'm hearing—and I share the concerns of Senator Ruston—and from reading the communique, there are no conditions placed on that 42.5 per cent, but it doesn't sound like the government is that committed to actually getting to it. It sounds like there are a whole range of things that would have to go right. What I'm hearing from Minister Stephen-Smith and other territory health ministers and state health ministers is that they are deeply concerned that this is just an ambition with no intention to get there. Minister, what's going on here?

Mr Comley: I don't think that's a fair reflection. The capping of the total Commonwealth contribution was always part of the agreement in December 2023. That's essentially because, in both hospitals and disability, the negotiations happen around what I might call the central estimate at the time as to how much is going to be required, and then also what are the risk management mechanisms that have to be put in place to recognise that things could change. The Commonwealth said at the time, and it's still the case, that the Commonwealth is prepared to put a significant increase in funding for hospitals compared with what had happened in the past, but it wouldn't be uncapped. The current estimate, which has been put in the public domain and which is the offer the Commonwealth put before the states and territories, is a $19.9 billion increase in hospital funding over five years compared with what would have been the case if you had provided a hospital funding increase of 6.5 per cent every year over the next five years. So it's a significant uplift. To achieve the 42.5 per cent would require not having very high growth in hospital expenditure over the next five years.

Senator DAVID POCOCK: Which would—

Senator RUSTON: You said the 19.9 is based on 6.5. You just said that it was a growth cap of eight—13 in year 1 and then eight. What would be the uplift if you applied that as it relates to the 19.9?

Mr Comley: Senator, what I'm saying is the $19.9 billion is the additional money on top if you had a 6.5 per cent growth rate. So effectively—

Senator RUSTON: How does that work? Can I just—

CHAIR: Sorry, Senator Ruston. You don't have the call; Senator Pocock does. If you're happy to share the call with the coalition—I'm not going to do the tick-tack thing in the middle of a call. If you're happy to follow up a question later on, I'm happy to give you the call to do a follow-up question, but I'm not going to do that in the middle of a call. Senator Pocock, you have the call. It's not an opportunity for an intervention.

Senator DAVID POCOCK: Can I ask about the National Efficient Price. Ms Stephen-Smith has said that small jurisdictions like the ACT cannot deliver services at the National Efficient Price. She says, 'With a different type of public hospital structure to the larger jurisdictions and the lack of economies of scale, it's not possible for us to deliver hospital services at the National Efficient Price. There should be a premium or a multiplier for small states that reflects the fact that they cannot deliver at a National Efficient Price'. She released data showing that it costs the ACT $1,999 more per patient than the National Efficient Price. Has the department received or seen this data or analysis from the ACT government showing that it can't deliver services at the National Efficient Price?

Mr Comley: I might just ask the others at the table to comment on whether we received that data. We've certainly been in conversation with not just the ACT but also other small states about whether they can meet the National Efficient Price. I don't want to take up too much time, but I just think it is important to comment that there is not really one National Efficient Price. There are a range of loadings that already exist within the system to allow for circumstances. The argument being put by some jurisdictions is that the adjustments are not sufficient for their jurisdictions. The tension here and the reason the National Efficient Price was put in in the first place was to try and drive efficiencies across the system. It's very hard—that's the last point I was going to make before going to the team. The tricky thing here is that it's very hard for the Commonwealth, which is a co-funder of hospitals, to control and influence a range of those things. So the point of the National Efficient Price is to try and drive those incentives at the state and territory levels. We are in the middle of negotiations, and every state and territory, not just the ACT or the small states, make claims continually that the National Efficient Price doesn't accommodate their needs. We just have to bear that in mind with the need to drive that efficiency across the system. But I'll just ask whether we've seen that particular data, because I know there have been periods of time we've asked for data but haven't received it from a number of jurisdictions.

Senator DAVID POCOCK: I'm asking you guys for data and I'm not receiving it, so please continue.

Ms Street: Senator, I can confirm that we have received recent data from the ACT in relation to these matters. But I think what's useful is some work that's being undertaken in terms of reviewing not the NEP but how the small state components fit in.

Ms Cahill: There's been a piece of work across all jurisdictions to work with the Independent Health and Aged Care Pricing Authority to look at how the current processes for determining the National Efficient Price weight for particular circumstances. That includes weightings of different kinds of patients in different locations. The specific concerns that have been raised and that IHACPA and jurisdictions are working together to do a review on are the weightings for First Nations patients, the weightings for ruralities—so location—and also for smaller jurisdictions. That is a process that's currently underway. All jurisdictions are participating in that, including the ACT, which is heavily involved in co-chairing the cross-jurisdictional group of officials that is overseeing that.

Senator DAVID POCOCK: When will that be completed?

Ms Cahill: I think at this point our expectation is that it will be completed in 2026.

Senator DAVID POCOCK: Is it first quarter, second quarter or any timeframe?

Ms Street: We can confirm that for you.

Senator DAVID POCOCK: Will the Commonwealth be taking this into account in negotiations? If you do find that there are legitimate reasons that small jurisdictions can't deliver those services for the same price, will that factor into the negotiations?

Mr Comley: I think it's genuinely difficult, when we're in a live negotiation with the states and territories, to be discussing which are the items we're open to negotiating or not negotiating, what's our red line and what we think we can't do. I think that is a genuinely difficult position to be in.

Senator DAVID POCOCK: Secretary, you're saying that, if your review finds that it's more expensive for, say, the ACT and Tasmania to provide health care to Australians, you can't even tell us if that will actually be factored into a landmark hospital agreement?

Ms Street: What we can say is it will be part of the NEP. If it changes the methodology for the National Efficient Price, that wouldn't form part of the negotiations per se, but it would impact on the underlying elements that feed into those estimates.

Senator DAVID POCOCK: Secretary, you said that you can't say whether it will factor into the negotiations, but did you not say earlier that you want the hospital agreements to be done by the end of this year, and this work will be done next year?

Mr Comley: Again, we're in the middle of a negotiation. It's not unusual for negotiations to not conclude every matter but also to leave processes open at the end of the negotiation because there's an ongoing process between Commonwealth and state. The idea that, in a Commonwealth state negotiation of this size, you get to the end and you've wrapped everything up with a bow—I don't think that is often the reality.

Senator DAVID POCOCK: Just to clarify today, could you please provide the contribution rate for each state and territory for the last three years?

Ms Street: For the last three years?

Senator DAVID POCOCK: Yes. Thank you very much.

Senator ANTIC: These are probably questions for the TGA. I want to ask a couple of questions. Some of these might have been covered before, but I don't think all. My questions are about adjuvants like thimerosal, which is mercury and aluminium, in the childhood schedule or in products that are on the childhood schedule. How many products on the childhood schedule currently contain thimerosal, the mercury adjuvant?

Prof. Lawler: We might need to take that specific number on notice. I do recognise as well that there has been a strong international conversation around the presence of thiomersal or thimerosal—it's called a couple of things—as a mercury-bearing adjuvant, and there has been a conversation around whether it is linked to adverse events. Again, there is not a strong international belief among regulators or, indeed, among the TGA that it is linked to adverse events of the nature that has been described.

Senator ANTIC: My understanding is it's been largely removed. There may be one or two, perhaps, which you can take on notice, of course, but largely it has been removed, I think, from most of the schedule. What are the reasons for that?

Prof. Lawler: My understanding—again, if this is incorrect, I'm very happy to correct the record—is that there is actually no thimerosal in childhood vaccines under the schedule that we use in Australia. Indeed, the

move that has recently been taken in the US is actually not removing it from childhood vaccines because, again, it's not present; it's removing it as a preservative in multi-dose vaccines.

Senator ANTIC: Is there a reason for it being removed? That's what I'm asking.

Prof. Lawler: My understanding is that it was removed some 25 years ago, so I'm not sure that we would necessarily have that.

Senator ANTIC: All right. Perhaps you can take that on notice as well. Aluminium as an adjuvant in the vaccine schedule though—how many vaccines on the current schedule have aluminium as an adjuvant? I hope I've said that right.

Prof. Lawler: You have indeed, Senator. Again, there are some vaccines that contain aluminium compounds, which can include aluminium hydroxide and aluminium phosphate. They are included as an adjuvant to bolster the immune response to the vaccine. Once administered, those adjuvants dissolve slowly from the site of injection and circulation and are eliminated through renal or urinary excretion. The exact number of vaccines and the nature of aluminium-containing vaccines, again, is something that we would probably have to take on notice if you're seeking that specific detail. We've answered a number of questions previously, but if we have answered that, I'll reference the question.

Senator ANTIC: Thank you. Can you then point me to any true placebo controlled studies on the use of aluminium in the vaccines to newborns?

Prof. Lawler: I'm not sure that I'm in a position to do that. Again, I think it's not my call to say whether they're fair questions or not, but these are questions that we can respond to probably in more detail in writing, if that's all right.

Senator ANTIC: Also, the hepatitis B injections given to newborns on their day of birth, I think, and again in coming months alongside the multiple antigen vaccines—is there someone here who can tell me the rationale for newborn babies having a vaccine for a disease which is largely in the domain of intravenous drug users and prostitutes?

Prof. Lawler: I'll throw to Professor Kidd, perhaps, to provide something after I comment. Obviously, again, there has been a significant amount of focus. I don't necessarily take it as a given that this is the province of intravenous drug users and prostitutes. I think that's not reflecting the public health initiative and the benefit that we've seen.

Senator ANTIC: What are the rates of hep B in the population that so urgently require newborns to be injected with the—

Prof. Lawler: I'm not necessarily in a position to provide that, but what I would say—

CHAIR: I think Professor Kidd is indicating that he might be able to help us here.

Prof. Kidd: Just briefly, Senator, people who are infected with chronic hepatitis B can transmit the disease, so that is a risk of transmission from the mother to the newborn child.

Senator ANTIC: What are the rates of hep B in the community then? Given that we give this to every newborn baby, what are the rates of hep B in the community then?

Prof. Kidd: We'll have to take that on notice.

Senator ANTIC: We're not having much luck today.

Prof. Lawler: I would highlight, Senator, if I may, that there has been a profound and clear decrease in the identification of the disease sequelae of hepatitis B. These include lifelong and debilitating conditions such as cirrhosis and hepatocellular cancer. They are clearly related to the introduction and the maintenance of neonatal immunisation for hepatitis B. This has been, again, a matter for discussion internationally, and it's recognised that it's been a significant public health intervention to decrease the significant morbidity and mortality associated with those conditions.

Senator ANTIC: I'm not disputing the fact that nobody wants a dose of hepatitis B, but the question is why, in every single incident, we're giving that. We seemingly don't do placebo controlled studies on the effects of it and the aluminium inside it. We're giving them to every newborn baby. The rates must be something in the order of 0.5 per cent of the population—whatever it is, whether it's two or whether it's one. I would love to know the rationale for giving every baby that at birth.

Dr Peatt: Senator, we do have Professor Katie Flanagan on the line, who's the Chair of ATAGI. She could maybe speak to some of the considerations taken by ATAGI when they put forward a recommendation for a vaccine to be listed on the NIP.

Senator ANTIC: Thank you.

Dr Flanagan: I've been listening with great interest to this discussion. My understanding is that 0.8 per cent of the population have chronic hepatitis B, which is actually quite a lot. It certainly isn't just—it's in a whole series of different people, particularly some of the culturally and linguistically diverse populations, and among many other populations. In fact, it's quite high in Aboriginal and Torres Strait Islanders. Every year, there are many thousands of notifications of new hepatitis B infections in Australia, so it is still a significant concern. Now, in terms of giving the vaccine to a newborn baby, it's the perfect time to capture a baby and start protecting it. It will protect against congenital transmission if the mother is infected and it wasn't known. In fact, many people in Australia who've got hepatitis B don't actually know they've got it. What we know is this is a vaccine that protects against cirrhosis and carcinoma later in life. So its effects are many years later, but capturing babies at that point starts to give them that immunity straightaway, and you still need multiple injections to actually get the protection. We know that this is an incredibly safe vaccine, and more than 90 per cent of babies in the entire world receive this vaccine at birth. The safety record on it is really quite impressive. It has been in policies globally for many years. That, I think, would be my response.

Senator ANTIC: You say that the safety is fantastic, except that we don't do blind placebo trials on it. The efficacy and safety really aren't fully established at approval if they're not then making a robust placebo controlled trial, not its omission. To me, that would seem like a more ethical position. By the way, 0.6 per cent of Australians have hep B, but we're giving it to 90 per cent of the kids. That's really strange to me.

Dr Flanagan: Well, because it can be transmitted to people, and you can get it if somebody in your family has got it, so the children can acquire it in that context.

Senator ANTIC: But nobody's got it.

Dr Flanagan: Well, 0.8 per cent of the population is still a reasonable number of people, I would say. We go back to the point of placebo controlled trials, which I think has already been addressed several times now today. You can't always do placebo controlled trials. Now, I would have to look back and see when the hepatitis B vaccine was first introduced and what the placebo controlled trials were. But there would have been before there was a hepatitis B vaccine. There's certainly going to be a lot of evidence in terms of the impact of when the vaccine itself was then introduced and how that would then reduce hepatitis B rates and also rates of hepatocellular carcinoma and cirrhosis. In fact, there are a number of studies globally that have been done looking at the impact of introducing the vaccine. Different countries introduced it at different times. So there is definitely a whole plethora of data out there, and there will be many studies looking at the safety of these vaccines as well. We know that these vaccines are efficacious. We know that most people do have a response, and we know that protects against acquiring hepatitis B, and then protects against, obviously, people having hepatocellular carcinoma, which is still a big problem in many parts of the world where hepatitis B vaccination isn't achieved.

Senator ANTIC: On the subject of the placebo controlled studies, is it the case that, even if a new vaccine is introduced, they are not done on that new vaccine? For example, Infanrix was introduced in 2006. I understand that, in years gone by, the Reagan administration introduced legislation in the United States which gave immunity to the companies that produce these drugs as a result of whatever. It seems that the process of not doing these full placebo trials stems from that. But the current introduction—a current drug would surely leave the door open for doing them now. Why aren't they done now? Why aren't they demanded to be done now?

Dr Flanagan: I'll start to answer that, and I'm sure Professor Lawler can also take this up. Yes, they are still done in the early phases of actually testing many vaccines. Many of the phase 1, phase 2 and phase 3 trials will have a placebo arm. But I have to say that quite often it's a different vaccine that's used as the placebo arm that then doesn't cause any effects on the disease that you're trying to test against. I've been involved in malaria vaccine trials, and we would often give another vaccine because we're trying to actually make it fair for people to be taking part in vaccine trials. Just giving them a placebo when we're trying to vaccinate lots of children isn't always as ethically well received. So they are done. As Professor Lawler said, we will try and get the evidence around placebo controlled trials and which ones they have been done for. But definitely, of course, over the years, the regulations and the rules have changed. And maybe many years ago, for some of the earlier vaccines, they were not done. But safety and efficacy trials are always done. You wouldn't introduce a vaccine in Australia unless it was shown to be safe and efficacious and the benefits outweigh the risks. When ATAGI is considering any vaccine, we have very robust and long discussions going through all the literature that we can find about safety and efficacy of vaccines. We're always keeping a watching brief on all vaccines that are coming through and any new emergent data to suggest that a vaccine might not be safe or that there might be a safety signal that leads to changes in our recommendations.

Prof. Lawler: Can I just add to Professor Flanagan's response there. In the right setting, with the appropriate ethical underpinnings, it is absolutely the case that we should be pursuing the highest level of science, which in that instance includes a placebo controlled trial. But it is important to note that they are not the only sources of evidence that we use. There is the comparison with the current accepted level of treatment. The process that we undertake, particularly for therapeutic goods that have been in use for many years and those that have been on the register for many years, includes, as Professor Flanagan highlights, the appropriate use of post-market monitoring, pharmacovigilance and the identification of safety signals being raised by those who use it or those to whom it's been administered, from other regulators and from health professionals. There's also the accumulation of decades of real-world evidence that can be used to point not only to effectiveness but also to safety and quality. It's on that basis that we're comfortable that the risk-benefit analysis for the vaccines that we approve and that are included by ATAGI in their recommendations for the immunisation schedule remain appropriate for that use.

Senator ANTIC: We're still comfortable with the COVID shots being safe and effective?

CHAIR: Senator Antic, I need to give the call now to Senator Steele-John.

Senator STEELE-JOHN: Professor Lawler, before I get to my main line of questioning, I just wanted to give you the opportunity to clarify that, during your last exchange with Senator Antic, when you quoted the senator's phrasing of hepatitis being something associated with 'drug users and prostitutes', you were not, in fact, endorsing the use of such a derogatory term to refer to sex workers.

Prof. Lawler: In absolutely no way. Thank you for raising that.

Senator STEELE-JOHN: Thank you. I just wanted to make sure the record was clear on that.

I'll go now to the question of the TGA's regulatory response to what is rapidly becoming a bit of a national public health scandal in relation to sunscreen. I refer, of course, to the Choice report issued in June of this year, where it was revealed that some 16 of 20 sunscreens surveyed and tested by this consumer group did not, in fact, meet the SPF standards as advertised. We have seen announcements of significant recalls of sunscreen products and the voluntary decision of a lot or some of these manufacturers to withdraw them from the shelves. There's a lot of concern in the community, given we are now in spring heading towards summer, and we know that skin cancer is one of the most prevalent cancers in Australia and that, of the five lines of defence against skin cancer, sunscreen is one of them. Now, I understand that the TGA doesn't currently conduct its own testing in relation to every listed sunscreen and instead relies on data from or provided by sponsors. Is that correct?

Mr Clarke: Sunscreens are regulated within a risk based framework in the TGA, so we apply a proportionate level of controls compared to the risk. Things like prescription medicine would go through a full pre-market screening before they're on. Sunscreens are regulated as listed medicines, so they would go through to be listed. The sunscreens would need to use ingredients from a pre-approved list. They would need to have indications or claims from a pre-approved list. Then sponsors would certify under law that they hold evidence to substantiate their SPF claims and that they meet the standards of safety, quality and efficacy.

Senator STEELE-JOHN: How does the TGA go about verifying the accuracy of the data provided by sponsors?

Mr Clarke: That would be through our post-market compliance action. Our work on sunscreens has been ongoing. For example, prior to the Choice report, which I'll acknowledge we have prioritised—and we completely understand the public response and appreciate the public interest, and we have dedicated considerable resources to investigating. But, prior to that, we would have ongoing compliance activity. For example, in the case of sunscreen, in 2018 we surveyed 20 per cent of all sunscreens on the market—175—and checked their SPF data, and all for one could substantiate those claims. Then we tested sunscreens over the course of the last few years on a range of things like broad spectrum protection or the quality of preservatives against microorganisms. That is ongoing. In relation to Choice specifically, we are investigating those specific sunscreens named in the Choice report as a priority. We have tried to be as transparent as possible, given the public interest, and providing regular updates.

I would say in relation to sunscreen, and going back to your statement about how important it is in sun protection, we acknowledge that sunscreen is very important in protecting Australians from the dangers of ultraviolet radiation in conjunction with those measures you discussed—wearing a hat, protective clothing and sunglasses; and seeking shade. Within that context, we also appreciate that SPF levels, and certain SPF levels, can still provide high levels of protection. An SPF 30, for example, would provide 97 per cent protection from UV rays compared to an SPF 50, which would be 98 per cent. Even an SPF 25 would provide 96 per cent protection from UV radiation. Within that context, we've been taking a risk-based approach and focusing on those

sunscreens that may provide significantly less protection that is advertised. You may have seen on 30 September—

Senator STEELE-JOHN: I did, yes. I want to just go to the next part of the question, which is a part of that response to Choice's recommendation. One of the recommendations was that the TGA conduct its own testing. You've said, as part of your response more broadly, that you're taking into consideration options that don't include human testing, also known as in-vitro testing methods. Noting that the TGA sunscreen regulatory role is one that has previously been quite highly trusted by the Australian community, I would argue that the more that we can do in this space to ensure that your capability to provide that assurance and that quality testing, the better. What are the barriers that you see currently sitting between the TGA and actually conducting that in-vitro testing?

Mr Clarke: I'll pass that over to my colleague Dr Kerr. Before that, I'll just acknowledge that the things you're asking are things we're thinking about, and we are very much using this as an opportunity to see where we can strengthen our regulatory system.

Dr Kerr: Your question was about the barriers for implementing testing. Until December last year, the only internationally recognised test to come up with the SPF value used humans. That's the in-vivo test, ISO 24444. The TGA does not have the facilities to test on humans, and we don't test on animals. So that's a significant barrier for us. However, in December last year, ISO, the independent body that drafts international standards, published an in-vitro standard, which we are capable of implementing, and we are taking steps to implement that standard.

Senator STEELE-JOHN: When will that standard be implemented?

Dr Kerr: I am hoping in the next few months.

Prof. Lawler: This is clearly an issue that has been a very strong focus for the TGA, as I know it has been for the country. It is actually a particularly strong example of the role of a risk based regulator. We recognise the challenges in this space. It's also worth pointing out that sunscreens are regulated in a different way in Australia to the way they are regulated in the rest of the world. In many countries, they are regulated as a cosmetic. We recognise, as you've highlighted, the prevalence and the impact of melanoma and other cancers means that it is an essential therapeutic good in Australia. We need to be both proportionate and balanced in the way we approach it, and they are two different things. The proportionality of the tightness of our regulation needs to be relative to the effectiveness and the quality of the products and the risks they present. But we need to balance both pre-market and post-market. We could be very tight with our regulation, which would mean that no products are authorised. But what we've taken is a risk based approach, not only in authorising these products but also, as Mr Clarke and Dr Kerr have highlighted, in monitoring and ensuring their safety and quality.

Senator STEELE-JOHN: I agree with you 100 per cent. In Australia, sunscreen is an essential therapeutic good, and it is right that the public expect it's regulated in that way. Is it correct that SPF makeup, SPF foundation and some SPF moisturisers are not, in fact, regulated by the TGA in the way that other sunscreen products are?

Mr Clarke: Yes. There is a differentiation between primary and secondary sunscreen. Primary sunscreen is that whose primary purpose is to protect a user from UV radiation. Those need to be registered on the Australian Register of Therapeutic Goods before they can be sold. Also, moisturisers that make claims over SPF 15 need to be registered on the ARTG. However, there are exclusions for what we'd consider to be cosmetic sunscreens. Those could include tinted foundations that have higher SPF ratings, as well as moisturisers that claim an SPF of under 15.

Senator STEELE-JOHN: To be clear, I'm looking at your website, which seems to list the excluded sunscreens, such as tinted based foundations, liquids, paste, or powders with an SPF of four or more. They're not regulated by the TGA; correct?

Mr Clarke: They're still regulated. Those would still be regulated under the Australian Industrial Chemicals Introduction Scheme.

Senator STEELE-JOHN: But not by the TGA?

Mr Clarke: No, they wouldn't be regulated by the TGA.

Senator STEELE-JOHN: And the Australian industrial regulatory framework—does that undertake testing as to the accuracy of the SPF claims?

Prof. Lawler: I'm not sure that we can necessarily best answer that. That's probably a question that's best put to the Australian Industrial Chemicals Introduction Scheme. We can provide that though.

Senator STEELE-JOHN: It doesn't appear that it does, from what I can see of their framework.

Prof. Lawler: I would just highlight, as Mr Clarke has said, that predominantly it goes to the primary intended use of the product and the SPF. When it comes to it, if it's introduced as a cosmetic, there is a strong industrial chemical introduction regulatory approach. If it's a therapeutic good, if it has a certain SPF claim, and it's primary use is as sunblock or, indeed, if it makes therapeutic claims, we regulate it as a therapeutic good at the TGA.

Senator STEELE-JOHN: Basically, the decider there is whether or not it's included on the excluded products and goods list, isn't it?

Prof. Lawler: Whether it features on that excluded—

Senator STEELE-JOHN: If it's not on that list, it's not in your purview to regulate somebody else's?

Prof. Lawler: No, if it's not on the excluded list—

Senator STEELE-JOHN: Sorry, if it is on the excluded list.

Prof. Lawler: If it is on the excluded list, that's right. Again, it's predominantly because of the claims that are made, and its constitution and whether it's primarily intended as a sunblock.

Senator STEELE-JOHN: My concern here, and this is both to you as a regulator and also to the government, is that many people use SPF makeups and foundations, and the very products that are listed here as things that the TGA does not regulate as sun care and prevention products because of the claims that they make. I've got a number open on my laptop right now that make a very clear SPF 50 plus rating claim on the product branding. Yet, putting aside the challenges that have been revealed with the TGA's regulatory process around sunscreen, at least you're doing something in the space and trying to do better. It is unclear to me whether these other regulatory bodies even believe it is within their obligation whatsoever to test for the accuracy of the SPF claim, as opposed to simply listing the ingredients within the substance.

Given this, I want to go to the minister and ask very directly. We are heading into summer. People are out in the sunshine right now. Most days in our country, the UV levels are such that, for a majority of the community, the Cancer Council recommends you wear UV protection. There are products here that are overwhelmingly marketed towards women, and it is unclear at best, if not definitively able to be determined, that there is no government regulatory function—testing as to whether they are actually sun-safe and whether the claims that they are making to protect you are in fact accurate or in any way backed up. Are you considering amending the excluded goods list so that these substances—these products are basically being marketed as sunscreen with foundation, if you look at the actual marketing—are regulated in the future by the TGA?

CHAIR: Before you answer, Minister, I'm just signalling to you, Senator Steele-John, that I will be shifting the call to share amongst other senators. So I'll wait for the answer of the minister, but I will be shifting the call once her answer is delivered.

Senator McCarthy: I have been listening intently, actually, to your conversation around this and the details which the TGA's provided. We have focused very strongly on cancer and the communication and are working with the Cancer Council around many issues, not least of which is the treatment of it. So I'll certainly take your question on notice in regards to the specific point that you've raised. So thank you for that.

CHAIR: Senator Nampijinpa Price.

Senator NAMPIJINPA PRICE: My questions relate to the proposed closure of the private maternity services in the Northern Territory and state and territory funding agreements.

Mr Comley: Just to be clear, you talked about the private maternity and you also talked about the National Health Reform Agreement funding. So it was the two issues, the closure of maternity and private, yes?

Senator NAMPIJINPA PRICE: Thank you. I'm just wanting to understand whether the federal government, in its funding agreements with states and territories, is considering models that integrate or support private obstetric-led care, given evidence that public maternity care is associated with higher rates of stillbirth and maternity complications?

Mr Comley: I'm not sure if you were in the room. I did make a comment to Senator Pocock that, as the Commonwealth-state negotiations are currently afoot with a view that they go for the next two months, there are some things that it's a bit hard for us to discuss. I think, in this case, I can say that private maternity services, to date, have not been rolled into a conversation about the broader National Health Reform Agreement negotiations between the Commonwealth and the states. We obviously do, as the Commonwealth, continue to have conversations with states and territories where there are specific services that will have had financial difficulties. In maternity, Darwin is one, and the other that has been recently an issue has been Hobart's maternity services, all related to Healthscope's access. Without sort of giving too much away, the broader Commonwealth-state negotiations to date haven't rolled in private maternity services to that conversation.

Senator NAMPIJINPA PRICE: To date?

Mr Comley: Yes. I mean, sorry, this is why I'm cautious because we are still negotiating with states and territories. I can't rule out that any state and territory may wish to put another issue on the table at some point in time, which they wish to negotiate, whether they want to negotiate that as part of a kind of multilateral agreement, or whether they wish to deal directly with the Commonwealth. I just can't rule out that someone wouldn't make those representations.

Senator NAMPIJINPA PRICE: I suppose with the Northern Territory recording the nation's highest rates of stillbirth, congenital syphilis, rheumatic heart disease and preterm birth, what is being done at a federal level to adapt maternity models to these particular complex needs?

Ms Street: There are a number of elements to your question. I think I would say that, in terms of the models of care, we do provide support for birthing on country. As you're aware, we have a number of different models that we support that go to First Nations more broadly. In terms of a model of care, specifically, say in the NT, we haven't got a piece of specific work on that at this point in time.

Senator NAMPIJINPA PRICE: The proposed closure of the private maternity services will impact particularly across those areas. Has there been any consideration given to this impact, going forward?

Ms Street: Yes. We have been in conversations with the Northern Territory government in terms of the impact of the closure of the Healthscope hospital. Unfortunately, I don't have everyone here with me because that's under outcome 2, the private side of things. We have been in conversations with the Northern Territory government about supports that they may seek from government, but there haven't been any outcomes from that at this stage.

Senator NAMPIJINPA PRICE: Why didn't the government intervene to sustain the private maternity services in Darwin when studies show they are more cost effective and, I suppose, safer for patients?

Ms Street: Can I get you to repeat the question, because I don't think that we have concerns in terms of the safety.

Senator NAMPIJINPA PRICE: Health is everybody's responsibility at a state, territory, federal level. I suppose I'm wanting to understand why the federal government has not intervened to sustain the private maternity services.

Prof. McMillan: Can I confirm that, in referring to private maternity services providing particular outcomes, are you referring to the recent published study by Callander et al that provided a perspective or a view that in fact private maternity did provide better outcomes than those of the public sector? Is that the basis of your questioning? Because it would be fair to say that there's been a significant response in relation to that publication. There is significant evidence that is contrary to that in relation to that study and a belief that the study didn't appropriately adjust for a range of variables before it was published.

Senator NAMPIJINPA PRICE: No. I suppose my concerns are more to do with—there was a report. There are a number of reports that I am referring to, which I can have emailed. Specifically, we have—of which there is evidence—the highest rates of stillbirth, congenital syphilis, rheumatic heart disease and preterm birth. As well as that fact, the proposed closure of the private maternity services will now apply pressure to the system. I suppose, with that in mind, I'm trying to understand why the federal government hasn't intervened.

Prof. McMillan: Ross?

Mr Hawkins: As Ms Street said, it typically comes up under outcome 2. We've got our private hospital expert coming this afternoon, but I'll try and answer as much of your question as I can. I am very conscious that the facility you're referring to in Darwin is run by Healthscope as a private company, and it's their decision as to how and which services are provided within that private hospital. I haven't got the exact date here when they kind of told us that was closing, but there's a level of engagement they had with the Northern Territory government. Then there was a level of conversation—I think it was over three- or four-month period, around what the transfer of those services back into the public would look like and what would need to be done in between. This includes elements of the workforce and the support mechanisms that would typically be in place as they close down their services and that would be relocated into the public system. I think that's where Ms Street was saying that there would be further conversations as part of future hospital agreements around what the jurisdictions would want to do as part of that. But the closure of the private hospital was a decision for Healthscope that they made at that time.

Senator NAMPIJINPA PRICE: What, if any, modelling has been conducted as to the knock-on effects of the closure, including to paediatric services and the litigation risks and insurance costs that clinicians have warned of?

Mr Hawkins: We'd probably need to take that on notice, largely because it would be an issue for the Northern Territory government. The Northern Territory government provides the maternity services for the population up there, and they would have looked at what the impact of that would have been with the private work coming back in. We can take it on notice and engage with them on whether they've done any modelling and what that might look like.

Senator NAMPIJINPA PRICE: I'd appreciate that. How is the federal government addressing the fact that Northern Territory families are being forced to travel interstate for their private maternity care and often for a period of up to 12 weeks?

Mr Hawkins: As I understand it—again, our expert is here this afternoon—I think there is still going to be a level of private offering within the public hospital. That has been an issue that the government have been discussing with health insurers. But we might be able to provide a bit more detail on that for you later on this evening.

Senator NAMPIJINPA PRICE: I would appreciate that. While it's claimed that numbers fell from 700 births a year to fewer than 300 in the private system, does the department accept that this oversimplifies the issue, given the overwhelming complexity and national worst numbers for maternity outcomes, as I've previously mentioned, in the NT public system that they have to negotiate?

Mr Hawkins: That might be one for the chief midwifery officer to answer, because when you do get to certain levels of birth—and we've certainly seen this in the private system—we find that private operators feel it's no longer safe to offer a service, largely to keep the necessary staff with the expertise on hand. That's why we've seen some closures across the country of maternity services historically, because the number of private births has dropped off. But it is an important factor that leads to the delivery or effective delivery of a safe and efficient service.

Prof. McMillan: Yes, there is obviously a point at which with very low numbers of obstetricians in this situation, or paediatricians, you may not be able to sustain a service going forward. What I understand has been put in place is that the Northern Territory government has put in an interim arrangement with a midwifery-led model of care to support local communities with birthing so that, where possible, it can be supported within the public system. That can be supported by the public health system in the Northern Territory. So there have been changes made so that the use of private midwives can be sustained in the interim while further consideration to service provision is made by the Northern Territory government.

CHAIR: Senator Price, I'm just checking how much more time you need. My understanding was that Senator Blyth was going to share some of the coalition's block of questions. So did you—

Senator NAMPIJINPA PRICE: Well, I've got some questions that I can put on notice. That's fine.

Senator McCarthy: Chair, can I just conclude on Senator Price's questions?

CHAIR: Yes. I would be happy for you to do that.

Senator McCarthy: Just in regard to a follow on in relation to the assistance to the Northern Territory, the Northern Territory government is set to receive over $550 million in terms of extra support in the Northern Territory for hospitals. That's about a 30 per cent increase, which is the largest it's ever received in 10 years.

Senator NAMPIJINPA PRICE: Is to receive that?

Senator McCarthy: That's right; in 2025-26. So it's set to receive it.

Senator NAMPIJINPA PRICE: Thank you.

CHAIR: Senator Blyth.

Senator BLYTH: My questions are to the NHMRC, so we might need to play musical chairs again. On 3 April 2025, the Adelaide *Advertiser* reported that 22 children were treated between 2023 and 2024 who were approved for gender transitioning without psychiatric assessment. Were you notified of that formally by SA Health?

Mr Singh: No, Senator, but I might mention that our role in this matter is to produce guidelines, so there is no obligation for states to inform us of that sort of information.

Senator BLYTH: Just to clarify, there are currently no formal guidelines in terms of young—

Mr Singh: There are no NHMRC approved guidelines relating to gender dysphoria.

Senator BLYTH: So we've got gender clinics that are using standards of care, and we've got instances where there have been children—in this case, the youngest was 11—who are being treated without any guidelines existing. We're not expecting to see this review come up with anything until mid-next year, is my understanding. Do you concede that that might be problematic in terms of the care of young people in Australia?

Mr Comley: Senator, we did this quite extensively earlier. There are no national guidelines, but the point that was made by Dr Develin and others that there are other clinical guidelines from professional bodies and others. So I think maybe Dr Develin might want to restate some of that evidence.

Senator BLYTH: I understand. If there are no guidelines, though, and we've got clinics that aren't even following their own duties of care that they have by not fulfilling things like psychiatric assessments, there are clearly gaps in the system. Young people are I guess, receiving treatment that they're not even being assessed for, which is really disturbing.

Dr Develin: The guidelines have evolved from the professional bodies that are providing these expert services. It's not unusual, in an area of practice which is evolving—gender dysphoria services are an evolving service—that these guidelines are developed by the expertise and the professional groups who are providing the services. Now we've been asked that the NHMRC provide that sort of national guidance. In response to the notion of best practice, certainly the guidelines that many of the services which are provided by the states and territories are operating under, they're very clear that multidisciplinary care is particularly important for this. That might include psychiatric or psychological services, social workers, those sorts of things. There is a sense that there should be a team wrapped around these children and their families.

Senator BLYTH: I'm not disputing any of that. What I'm saying is that these teams aren't clearly aren't working together, and children are being prescribed medications—we've recently had a Federal Court decision where Justice Strum basically endorsed the Cass review. He ruled, basically, that the risk of harm of puberty blockers was considered unacceptable. I guess what I'm looking at is that there's a whole lot of young people, and we're not expecting to have any official guidelines or even interim guidelines in place until next year. What happens to all of the young people between now and then? Because they're being harmed currently.

Dr Develin: I wouldn't accept some of the assertions around 'the children are being harmed'. I would point you to the *Medical Journal of Australia*, which only two days ago released an interesting study, which was an Australian perspective on the Cass review, and it did demonstrate that some of the comments in the Cass review are not relevant in the Australian context in the notion of the services. It did actually suggest that some of the findings of the Cass review weren't accepted by the sort of expertise in Australia. That might be an interesting study for us to think about going forward. In terms of what is happening now, the states and territories are offering these services under their clinical governance models, and they are responsible for ensuring the clinical governance of their services, and that their health professionals are operating to their appropriate scopes of practice. So it is a matter for the states and territories in terms of the quality and safety of the services that they offer their community.

Senator BLYTH: Will the—

CHAIR: Final questions, Senator Blyth.

Senator BLYTH: Are puberty blockers being considered to be listed on the PBS for under-18-year-olds?

Dr Develin: The PBS team would need to answer that question for you in terms of what pharmaceutical sponsors may have brought forward those medications.

Senator BLYTH: Are they here now to be able to answer that?

Mr Comley: Yes, they are.

Prof. Wesselingh: While we're waiting, I'd say the minister has asked the NHMRC to provide interim guidance on puberty blockers by the middle of next year, so that is our intention, and that guidance will be available by that time.

Senator BLYTH: My understanding is that that was urgent advice the minister had requested.

Prof. Wesselingh: Yes.

Senator BLYTH: Do you think the timeline meets the definition of urgent, in your view, when we've got young people who are being treated with no formal, overarching national guidelines currently?

Prof. Wesselingh: I think that we need to make sure that we get the answer right, that we look at all evidence, that we look at it in the Australian context, and that we take evidence from a large number of people, including people with lived experience, in order to come up with that answer. I think that time actually is the right amount of time, and it is actually quite short.

Mr Comley: The officer here with respect to PBS is not aware of the answer, but we have PBS under outcome 2, so we'll endeavour to come back with a specific answer to your question then.

Senator BLYTH: Sure. Thank you.

Senator DAVID POCOCK: I've got some questions about bulk-billing.

Mr Comley: Sorry, Chair, with your indulgence, I was just looking at it now. Bulk-billing and bulk-billing rates we would say are under outcome 2. I was just looking at the way the agenda is put forward and the practice incentives. For example, if you're interested in the ACT clinics, they're kind of primary health funding in the same way PHNs are, and they're under outcome 1. I acknowledge there's a bit of a split between the two.

Senator RUSTON: So we are sticking with that?

Mr Comley: Well, I think it depends. Sorry, Chair; it's your call.

CHAIR: The question would be whether the correct officials are here to answer the questions.

Senator DAVID POCOCK: I've just got questions about the PIP, the Practice Incentives Program.

CHAIR: Which is outcome 2.

Mr Comley: I think it's outcome 1, whereas the actual broader MBS and bulk-billing rates are outcome 2.

CHAIR: So you're asking questions about outcome 1?

Senator DAVID POCOCK: Yes.

Senator RUSTON: Can I just put on notice your officials in relation to this whole package. I'm likely to ask them in outcome 2. So if there's anything that's likely to be in overflow from outcome 1, could you make sure your officials are still here tonight? Thanks.

Senator DAVID POCOCK: Thank you. My understanding is that the PIP, the 12½ per cent payment, is due to commence on 1 November. It's a quarterly payment of 12.5 per cent split evenly, fifty-fifty, between GPs and practices if the practice bulk-bills all eligible services within the quarter.

Mr Roddam: That's correct, Senator.

Senator DAVID POCOCK: When does the first eligible quarter end?

Mr Roddam: We're expecting the first payments to be in January. The program commences on 1 November, so three months from then.

Senator DAVID POCOCK: How soon after you get the data do you make the payments? How does that work? Is it a pre-commitment that for the next quarter they're only going to bulk-bill?

Mr Roddam: It's paid in arrears, essentially. As I say, we expect the first payments to be in January.

Senator DAVID POCOCK: Do you have a timeline from receiving data to making payments in mind?

Mr Roddam: Well, payments are made by Services Australia. I'll just check. Ms Da Rocha, do you have anything to add?

Ms Da Rocha: We will make them quarterly in arrears. That first quarter will be a part-quarter, from 1 November through to December, and we'll make the payment in January via Services Australia.

Senator DAVID POCOCK: Do you have a rough indication from Services Australia how long it will take to release that payment?

Ms Da Rocha: I expect that it will be early in January. We don't have that level of detail at this time.

Senator DAVID POCOCK: Maybe on notice you could provide advice on that. Will you be reporting publicly how many practices were paid the PIP in January?

Ms Da Rocha: It depends on how many sign up to the Bulk-Billing Practice Incentive Program. It opens on 1 November, so it really depends on how many sign up.

Senator DAVID POCOCK: Sorry, that was a poorly phrased question. Will you be making publicly available how many have signed up and received the PIP? What's the public reporting of this data?

Ms Da Rocha: There is a requirement under the program that all bulk-billing clinics will need to register on healthdirect, so it will be publicly available.

Senator DAVID POCOCK: Each quarter?

Ms Da Rocha: In order to receive payments, they will have to register on healthdirect to say that they're a bulk-billing clinic and they'll have to display appropriate signage.

Senator DAVID POCOCK: Will the department be releasing the number of clinics that are—

Ms Da Rocha: We haven't got to that stage. Our real focus at the moment is on opening on 1 November, which we expect to happen, and then we'll go to the reporting arrangements.

Senator DAVID POCOCK: Maybe on notice, the reporting arrangements, please. How many practices are you expecting to uptake the PIP in November for the first part-quarter?

Ms Da Rocha: We don't have an estimate.

Senator DAVID POCOCK: No estimate?

Mr Roddam: Our modelling shows that around 4,800 practices will be better off through the program, but we don't have a particular timeframe in terms of sign-up to the program in that forecast.

Senator DAVID POCOCK: How many are you expecting to take up the PIP by 2030? Do you have that figure?

Mr Roddam: Nothing beyond our modelling our that shows that 4,800 practices will be better off, as I said.

Senator DAVID POCOCK: Do you have anything on the ACT? I think last time we spoke it was 25 fully bulk-billed practices. Has that changed?

Mr Roddam: I'd need to refer to my colleague Mr McCabe.

Senator DAVID POCOCK: Have any signed up to date, or you can't sign up yet?

Mr Roddam: There's an expression of interest process, and many hundreds of practices have made an expression of interest, but we expect the number of practices to sign up to be well in excess of that.

Senator DAVID POCOCK: Maybe on notice you could let me know how many in the ACT have expressed interest. Thank you.

Mr Roddam: Yes, Senator.

Mr McCabe: We haven't had any change in our predictions or modelling since the evidence I gave earlier in the year. It's still 25. We are—Mr Roddam might talk to this—doing some other things around grant payments and the like to encourage bulk-billing clinics in Canberra as well.

Senator DAVID POCOCK: If the PIP is going to deliver 25 bulk-billing practices, why is there a need for direct grants and payments in the ACT?

Mr Roddam: The government and the department recognise the particular challenge in the ACT. There is the initiative for three fully bulk-billing practices to be established in the ACT, with a $10.5 million election commitment, really recognising the particular challenges here in the ACT.

Senator DAVID POCOCK: Was that a recommendation of the department or a decision of government for the election?

Mr Roddam: That was an election commitment from the government.

Senator DAVID POCOCK: When will they be opened?

Mr Roddam: We expect the funds to flow—the process is being worked through at the moment in terms of the grants process. We expect a provider, or providers, to be selected this year and for funding to flow from the primary health network early next year.

Senator DAVID POCOCK: How many years is that for?

Mr Roddam: That's a three-year measure.

Senator DAVID POCOCK: What happens after the three years?

Mr Roddam: That would be a decision of government, and, I imagine, examining the success of the program.

Senator DAVID POCOCK: I've got some questions about the youth specialist care centres—I think there were 20—that were an election commitment. Thank you very much for that. Looking at the election commitment, I'm interested in where the 20 centres will be located and how far away you are from announcing locations and opening centres.

Mr Matthews: Mr Short can probably provide a bit more detail on the implementation of them, but, basically, it's a new initiative. The 20 centres that were committed will build on the eight early psychosis youth centres that we already have. It will expand those into a full youth specialist centre and will open up 12 additional centres, which will take it to the 20 that have been committed. They are a new service. They'll require a new model of care to be developed for those services. That will be the first step. In terms of locations, they haven't been settled yet, so we will be working and taking in a lot of factors and doing consultation, obviously, with states and territories

and a range of stakeholders around where they should be located. They're a fairly large, significant, complicated service to establish and run, so there will be a lot of consultation needed to set those up and work them out.

Also, because they're intended to go up into the more moderate and severe range, obviously, it is also fairly critical to get the connection with the states and territories right in terms of how it interfaces with those services. It will take a little bit of implementation time to get those timeframes right and do it. So we'll be working that out. The first step is the model. Then it'll work through into an announcement of the locations. Then there will be the commissioning of them. Then there'll be a period of time to stand them up and deliver them. It'll take a few years, but I'll get Mr Short to talk about—

Senator DAVID POCOCK: It'll take a few years to deliver them and to develop the model.

Mr Matthews: Yes, to deliver all 20 of them. All of those centres will be phased in over three to four years. Some will come in earlier, but they will take some time to get through that process and even get the first ones up.

Senator DAVID POCOCK: Do you have an idea on the timeline to finalise the model at least so that you can start the procurement?

Mr Matthews: Yes. We'll be doing that over the next probably six to nine months, but I'll let Mr Short provide some detail on timeframes.

Mr Short: The model development is happening now and will continue through to early next year. The funding and phasing for the youth specialist care centres starts from 2026-27 and has a three-year implementation phase. The rebrand of first four of the eight existing early psychosis centres will start in 2026-27, and then there will be two in 2027-28 and two in 2028-29. The 12 new centres, with locations yet to be determined, will be in 2027-28.

Senator DAVID POCOCK: So the 20 centres are actually eight rebranded existing centres and 12 new ones. Of those 12 new ones, will every state and territory have at least one youth mental health centre?

Mr Short: Just to be clear, it's a rebrand, but, also, it's a new model of care.

Senator DAVID POCOCK: Sure.

Mr Short: So it is an expansion of the early psychosis model to a transdiagnostic model of care for young people with severe and complex mental illness.

Mr Matthews: There will be a much larger and more intricate service than the existing early psychosis youth services.

Senator DAVID POCOCK: That's good to know. Will every state and territory have at least one youth mental health centre?

Mr Short: That decision has not been made yet. We are providing advice to government now on need. We're doing our national needs analysis work to provide advice to government on the locations for those 12. That has not been decided.

Senator DAVID POCOCK: How could—

CHAIR: Thank you, Senator Pocock. I do need to share the call to Senator Ruston.

Senator RUSTON: Thank you very much, Chair. Just quickly, before we move on to the next topic, Secretary, could you provide me with the document that backs up your statement that you made previously in relation to the National Cabinet around the NHRA about the conditionality of—

Mr Comley: I'll take that on notice.

Senator RUSTON: Thank you very much. I want to quickly ask some questions on the National Drug Strategy and smoking. Does the department actively monitor the illicit tobacco market and its impact on smoking rates?

Ms Clancy: The department monitors smoking rates in general. From a health perspective, obviously, smoking is, and continues to be, the No. 1—

Senator RUSTON: I don't want to be rude. We are on such a tight timeframe. I'm just interested in whether the department monitors the illicit tobacco market.

Ms Clancy: No. We monitor tobacco consumption.

Senator RUSTON: You don't differentiate. If you're doing tobacco, you obviously must be able to differentiate between how you would collect statistics on the illegal versus the legal market. Would that be correct?

Ms Clancy: We collect statistics on smoking in general.

Senator RUSTON: Yes. But you can't be collecting the data on smoking in general. In the same manner, you must collect data in relation to illicit tobacco differently to how you collect—or don't you?

Ms Clancy: We collect data—such as: Do you smoke? Do you smoke daily? Do you smoke regularly?

Senator RUSTON: So this is a survey. This is part of the National Drug Strategy Household Survey. Is that the only way that you collect that data?

Ms Brown: We monitor a range of different data sources in relation to smoking prevalence. In relation to the National Drug Strategy Household Survey that you referred to, there are questions that collect, at a high level, smoking prevalence. That is any smoking of any tobacco product. There are also questions in that survey that relate to smoking of unbranded tobacco products, which is used as a proxy for—

Senator RUSTON: Do you do any other collection of data in relation to the use of tobacco or nicotine outside of the survey?

Ms Brown: The government has provided investment in a range of different data collection, but those, as Ms Clancy mentioned, are aimed at monitoring prevalence of smoking in the broad. There are a range of data sources that the department monitors, in understanding—

Senator RUSTON: External data sources. So you do the survey yourself, but you would be looking at external data sources in terms of what other agencies are publishing in relation to what they found in their mechanisms of data collection. Is that what you're saying?

Ms Brown: That's right. If I may, I will just clarify that the National Drug Strategy Household Survey is conducted by the Australian Institute of Health and Welfare.

Senator RUSTON: It's still a government department. There was a Roy Morgan report released in July this year regarding smoking rates increasing since the introduction of vaping restrictions that came into effect, and there was a subsequent article in the *Saturday Paper* with claims that the study was amended following feedback. Did the department receive any feedback from stakeholders regarding that particular research document?

Ms Brown: Yes, the department did receive feedback from stakeholders regarding the Roy Morgan publication.

Senator RUSTON: Did the department make any representations, either formal or informal, to Roy Morgan or any other stakeholder concerning the findings or the feedback that you'd received?

Ms Brown: The department didn't make any representations to Roy Morgan in relation to the data. The department did engage with Cancer Council Victoria, who had undertaken separate analysis of a similar dataset to produce a report under contract with the department. We engage directly with Cancer Council Victoria to understand the differences between the analysis that they had undertaken under the contract with the department and the publication by Roy Morgan.

Senator RUSTON: Are you aware of whether Cancer Council Victoria had any contact with Roy Morgan?

Ms Brown: The Cancer Council Victoria had purchased the data that they used for their analysis from Roy Morgan. Yes, I understand they engaged with Roy Morgan in relation to that purchase.

Senator RUSTON: Our understanding, according to the *Saturday Paper*, is that the headline of the original article was 'Smoking increases among young Australians since "vaping sales ban" in 2024'. It was basically saying that smoking had increased since the vaping ban had come in. Then, within days of that being reported—it was known as, I think, finding 9936—the link was deleted. Minister, do you know whether the minister's office made any representations to Roy Morgan or any of the other stakeholders in relation to this issue?

Senator McCarthy: I can take that question on notice, Senator.

Senator RUSTON: Thank you very much. I want to ask some questions about the proton therapy facility in South Australia. What is the status of discussions between the federal department and the South Australian government and/or SAHMRI—either of those two bodies—is as we sit here today?

Dr Develin: We're in routine discussions with the South Australian government. The former South Australian Treasurer wrote to our minister in July seeking significant financial support for the project. Obviously, that request is still under consideration.

Senator RUSTON: Can you confirm to the best of your understanding that the South Australian government is no longer intending to purchase the proton therapy machine from Proton International?

Dr Develin: They did publicly announce that they had terminated the contract with Proton.

Senator RUSTON: Yes. To your knowledge, how much federal funding has been paid to Proton to date?

Dr Develin: We have paid $68 million, which was the federation funding agreement amount to the South Australian government, who were then working with SAHMRI and who had contracted Proton. I'll just see if my colleague has any further details on the split of how any of that money has been spent.

Ms Hermann: The $68 million was provided directly to the South Australian government. Of that, we understand, is approximately about $11 million that's still retained by the South Australian government that wasn't provided to SAHMRI. I don't have the detail of the funding that SAHMRI has provided to Proton International.

Senator RUSTON: Is it the federal government's intended commitment to the development of a proton beam therapy facility in Australia—and, in this case, in South Australia—and does the government remain committed to the delivery of that, Minister?

Senator McCarthy: Sorry. Just repeat the question, please, Senator.

Senator RUSTON: I was wondering whether the government still remains committed to the delivery of a proton beam therapy facility in South Australia for the whole of Australia.

Senator McCarthy: Thank you. I was just looking for my notes on it and realised I didn't have it in my pack. We are still working closely, obviously, with the South Australian government around the future of the project, including on recent work undertaken by the South Australian government to explore alternative technology supplies.

Senator RUSTON: 'Alternative technologies'. Is that alternative technologies to proton beam therapy or alternative providers of proton beam therapy?

Senator McCarthy: I take it that 'to explore alternative technology supplies' could mean both, but I'll take that question on notice.

Senator RUSTON: I'm just keen to understand. If you could take this on notice, I just want to make sure that you're not telling me that the government is no longer committed to the delivery of proton beam therapy for Australian patients.

Senator McCarthy: I don't believe I'm telling you that, Senator.

Senator RUSTON: No. I'm just seeking clarification, Minister; that's all. Is there any consideration from the government about considering a private pathway to get proton beam therapy operational in this country?

Dr Develin: As you're aware, the Australian government obviously still supports the Medical Treatment Overseas Program, which is how Australians access this therapy at the moment. I recognise—

Senator RUSTON: I was actually talking about in Australia—I'll come to that in a minute. I'm just interested in the this: is the government considering a private pathway to enable proton beam therapy to be delivered or to be operational in Australia?

Dr Develin: If I think about the number of patients that are likely to benefit from this sort of therapy, which will largely be children, the Cancer Australia strategy on proton suggested that it would be around 372 patients a year. That is a very small patient cohort, which is why you can see the nature of a public service being required, because it may not be viable for a private operator. However, all partnerships will be explored in this.

Senator RUSTON: Will be, or are being?

Dr Develin: We're currently considering the South Australian government's request.

Senator RUSTON: So there's no consideration being given at this stage to pursuit of a private pathway as an alternative pathway if the South Australian situation falls over?

Dr Develin: The South Australian government is obviously pursuing a public provision of service.

CHAIR: Last question, Senator.

Senator RUSTON: Have any MBS item numbers been approved by MSAC specifically for proton beam therapy?

Ms Hermann: I might wait for my colleagues in MBD to respond to that question, but I do know that there are specific MBS items for the purposes of comparative planning, which is looking at the benefits of proton versus photon therapy.

Senator RUSTON: I'd be keen to know, when the person turns up, how many numbers there are and whether those item numbers have been formally issued?

Mr McIntyre: Not to my knowledge, but we'll be able to cover that better under outcome 2. We'll confirm that when we have the outcome 2 folk here later this evening.

Senator RUSTON: Just to finish off on this one, because I know the Chair wants to go to the break, what is the cost to patients and the Commonwealth at the moment of the funding of the overseas treatment program that, Dr Devlin, you were referring to in your previous answer?

Dr Develin: That would be another colleague who will help you there.

Senator RUSTON: It's just that you raised it.

CHAIR: Thank you very much.

Prof. Kidd: Just a second, if I may.

CHAIR: Yes, Secretary.

Prof. Kidd: We do actually have a quick answer to that question. Through MTOP program, the Medical Treatment Overseas Program, in the last four years, there's been $31 million allocated to treatments.

Senator RUSTON: And you've no idea what the cost to patients has been?

Prof. Kidd: I can't tell you how many patients that involved.

Mr Comley: Once they've been given funding under the MTOP scheme, there's generally not cost to patients.

Senator RUSTON: I think patients would probably disagree with you—maybe not for the treatment but for the cost of actually having to go overseas.

Mr Comley: The MTOP scheme includes the airfares and accommodation necessary and also occasionally includes accommodation and fares for the accompanying people.

Senator RUSTON: Sure. It's a great program. I'm certainly not saying there's anything wrong with the program, but there is a cost still associated with people having to travel overseas as opposed to being able to get treatment in Australia. There's—

CHAIR: I'm just conscious of time. Thank you, Senator Ruston and Secretary.

Mr Comley: Just one last thing: Senator Ruston asked for a question on a timeline related to communication activity, and I have papers to table now, which I can table. They can be distributed, so we can discuss it after the break.

CHAIR: Excellent. Thank you very much for that. We will now suspend for a break. We are also saying goodbye to the minister, and we will have a new minister to welcome when we resume. We will be continuing in outcome 1.

Proceedings suspended from 16:01 to 16:19

CHAIR: The committee will continue on outcome 1, Health policy, access and support. I now wish to welcome Senator the Hon. Nita Green, Assistant Minister for Northern Australia, Assistant Minister for Tourism and Assistant Minister for Pacific Island Affairs, representing the Minister for Health, Disability and Ageing. Minister, did you wish to make an opening statement?

Senator Green: No. Thanks, Chair.

CHAIR: I will go to Senator Roberts.

Senator ROBERTS: I've got several issues here that I'd like to discuss—National Blood Authority about tainted blood, the pelvic mesh, the Lyme disease, ATAGI following on from Professor Lawler's comments. So I'll start with National Blood Authority, please. Is Dr John Rowell here? No.

A lot of people are plagued with tainted blood, a heavy burden. At CSL's 2024 annual general meeting, Chair Brian McNamee stated that, prior to its privatisation, the Australian government was the owner, funder and regulator of the Commonwealth Serum Laboratories. Is that correct?

Prof. Platona: The National Blood Authority was formed in 2003 as a statutory legislative agency. I'm very happy to answer questions about the National Blood Authority's role and work since 2003.

Senator ROBERTS: I'm wanting to know if you could confirm that before the Commonwealth Serum Laboratories was sold off to the public, the Australian government was the owner, funder and regulator of the Commonwealth Serum Laboratories.

Prof. Platona: I believe that is correct, sir.

Senator ROBERTS: What steps did the Australian government take to regulate the safety of the Factor VIII and IX concentrates manufactured by the Commonwealth Serum Laboratories in the seventies, eighties and nineties?

Prof. Platona: As I said in the first statement, the National Blood Authority was formed in 2003. I'm happy to answer questions about the work of the agency since then. You are referring to matters that precede the formation of the National Blood Authority by several decades.

Senator ROBERTS: Could you tell me—I know it was a long time ago, but a lot of people are severely suffering now. Whose responsibility was it at the time, Ms Platona—is it Professor?—

Prof. Platona: Yes. Ms Platona is fine.

Senator ROBERTS: to ensure the safety of the Factor VIII and XI concentrates? This has relevance to what you're doing now.

Prof. Platona: Indeed. The National Blood Authority was formed, as I said, as a result of some negatively affected people in the seventies, eighties and nineties. My predecessor provided a lot of context in response to your question in November 2024 on *Hansard*, as to the steps that led to the formation of the National Blood Authority, the apology, the formation of what is now the national Red Cross Lifeblood organisation, the apology that Red Cross Lifeblood made in 2014, and a number of actions by state and territory governments to deal with, really, the failings of the blood transfusion in the past. I do not want you to think at all that I don't think about the lives of the people that Haemophilia Foundation, for example, is working to support—not at all. I'm the officer that has got the Public Service Medal for making the direct antiviral medicines available. Those hepatitis C treatments are now considered to be best practice and curative. So I do want to acknowledge the hard circumstances of the people affected by the disease.

Senator ROBERTS: That's good. Did you want to say any more on that?

Prof. Platona: I'm keen to do a good job, Senator.

Senator ROBERTS: How can you do a good job for people with tainted blood? It was the government's responsibility.

Prof. Platona: Since the organisation was formed in 2003, to date there has been no contaminated blood incident.

Senator ROBERTS: Do you not have any legacy responsibilities from your predecessors? The Commonwealth government is responsible.

Ms Shakespeare: Prior to 1991, the Commonwealth's role was largely through providing funding to state and territory governments to operate blood services. States and territories regulated the blood supply system in Australia until, as Ms Platona has explained, the National Blood Authority was established in 2003, and it now provides that national coordination. I think we also had the Therapeutic Goods Act 1989. After that, there were changes to the way that blood was regulated as well. Before that, the regulation largely would have been occurring through state and territory governments.

Senator ROBERTS: But it was overseen by the Commonwealth. Let's go through the history, and correct me if I'm wrong, Ms Shakespeare. In March 1953, the World Health Organization released a report that recommended dried plasma should be prepared from small pools of no more than 10 to 20 donors. This was ignored, and, by the mid-1980s, factor concentrates were being manufactured using mass pooled plasma from thousands of donors, significantly increasing the risk of hepatitis and HIV. Why were these early recommendations ignored? You weren't around then, but that was a federal responsibility.

Ms Shakespeare: We can try and take on notice if there's anything in the archives about what happened in the 1950s, but it is a little bit difficult for us to talk to you about what happened at that time.

Senator ROBERTS: Could you take these on notice then, please. It was in the mid 1980s. Factor concentrates were being manufactured using mass pooled plasma from thousands of donors, which went against the prevailing wisdom. Could you find out, Ms Shakespeare—and I thank you for your attention—if it was considered an acceptable risk that there was a high probability of haemophiliacs using factor concentrates that would be infected with hepatitis Non-A, hepatitis Non-B, hepatitis C in the seventies, eighties and nineties?

Ms Shakespeare: Senator, what I can tell you is that the first specific test for hepatitis C became available in late 1989. Australia was one of the first countries to commence using the test, in November 1989, with implementation completed by February 1990. Similarly, we were one of the first countries to introduce HIV patient screening in May 1985. When tests have become available to make sure that the blood supply was safe and could be monitored for those particular medical issues, we've implemented that as early as possible.

Senator ROBERTS: I'm wondering how to help these people.

Ms Shakespeare: I think Ms Platona has spoken about some of the assistance that has been provided, and I can go through some of the help that has been provided. There was a review of the blood arrangements in 2001

that was conducted by a former High Court judge. The recommendations from that review were provided to all Australian Health Ministers and led to the establishment of the National Blood Authority and the centralised coordinated arrangements we have to ensure a safe and adequate blood supply that we still have today. We have haemovigilance—

Senator ROBERTS: Can I interrupt?

Ms Shakespeare: Of course.

Senator ROBERTS: That would assume that, prior to that, the blood wasn't considered to be safe.

Ms Shakespeare: Decisions will have been made based on the state and territory governments' delivery of blood products about the introduction of testing when it became available, when those tests were developed. As I said, compared to other countries, Australia was one of the first adopters and introduced those tests at a very early stage. But we didn't just stop there. We've been establishing arrangements to make sure that the blood products that we provide to people today are nationally coordinated, that we've got consistent arrangements and that we don't have differences between regulation and provision in different states and territories.

The national haemovigilance program for Australia has been developed. That's a set of surveillance procedures covering the entire blood transfusion chain, from donation and processing of blood to their provision and transfusion to patients. We have monitoring, reporting, investigating and analysing of adverse events related to donation processing and transfusion, and development and implementation of recommendations to prevent the occurrence or reoccurrence of adverse events. So we've got a whole haemovigilance program that now operates that's been developed and implemented through the National Blood Arrangements.

For people that have acquired hepatitis C the direct-acting antivirals, which were listed on the PBS in 2016—at that time that was the largest single PBS listing that had ever been made. We have future-generation direct-antivirals that are now provided through the PBS. If I can give an example, in 2023-24, we had 9,167 scripts of a drug called glecaprevir and pibrentasvir, which is a current-generation treatment for hepatitis C at a cost to government of $161 million. In the same year, sofosbuvir and velpatasvir, another medicine to treat people with hepatitis C, had 10,953 scripts at a cost to government of $131 million. So we're providing access to those treatments. Now that covers anybody with hepatitis C. It doesn't matter how they acquired it, but it would certainly benefit those who acquired it through the blood system before the testing was available.

Senator ROBERTS: For some of these people with tainted blood, their lives have been really shot. Perhaps you could look at the camera—and I'm not trying to put pressure on you, or Ms Platona, or the minister, but what do we do for these people? Where do they go for compensation? Britain compensated their people with tainted blood, long, long, long ago; they admitted it and got on with the job. How do these people recover? How do these people get compensation if they can't? I know you've given a list of drugs. What do we do?

Ms Shakespeare: Those are curative, in many cases, direct-acting antivirals, which will be of significant benefit to people with hepatitis C. I should also say that the Australian government contributes to the hepatitis C litigation settlement schemes, which were set up and are managed by the state governments for people that were infected through the blood supply system before we had the National Blood Authority established. That offers financial settlements for people who contracted hepatitis C between 1985 and 1991. So there has been compensation made available and the Australian government contributes to that.

CHAIR: Senator Roberts, I'm going to have to share the call. We are tight on time.

Senator ROBERTS: Thank you for your interest, Ms Shakespeare.

Ms Shakespeare: You're welcome.

CHAIR: Senator Payman.

Senator PAYMAN: My line of questioning is on the medicine shortages. The Royal Australasian College of Physicians said in March that, with over 400 medicines in shortage in Australia, increased production capacity in Australia was paramount. With the current Trump administration looking at implementing tariffs on pharmaceuticals, and big pharma taking aim at the PBS, the outlook for global supply of medicines is increasingly uncertain—I'm sure you'd agree with that. What's in the pipeline? What is the government hoping to do to ensure there's enough medicine in Australia for Australians who need it?

Prof. Lawler: We have responsibility for identifying and mitigating the impacts of shortages. I might just throw to my colleagues to speak about what we're doing—not only to respond, as and when these shortages arise, but what we're doing in a proactive sense to forecast and work with key stakeholders to be prepared and responsive. But then I might ask Mr McIntyre to talk around some of the work that we're doing in that space as well.

Dr Fenner: Within the TGA our responsibility, as Professor Lawler said, is to monitor the medicine shortages and the supply of medicines, and we do that with sponsors. Pharmaceutical companies must report to us upcoming shortages or discontinuations for prescription medicines and for a certain range of important non-prescription medicines. We work with pharmaceutical companies and peak bodies and stakeholder groups to minimise those impacts of shortages and work to ensure equitable supply. We, within the TGA, undertook a really comprehensive consultation in early 2024, and that included consultation with consumers, health professionals and industry stakeholders, to look at where we could improve our role within the TGA. We distilled that down to four themes that we've been progressing, in terms of reforms. They are, firstly, to look at updating our legislation to better be able to mitigate and take action for medicine shortages; secondly, to look at improving some of our data and digital capabilities; thirdly, to improve the way we communicate with health professionals; and, fourthly, to look at how we could better predict shortages. That work is ongoing.

This year, we have undertaken some reforms already to improve our legislative framework. We added around 25 medicines to our non-prescription medicines—to our list of medicines that must be reported to us. That includes things like IV fluids, which are really important. We're working through that program, developing some communication frameworks.

It's important to recognise what TGA can't do. we're a therapeutic products regulator. We can't compel sponsors or companies to make applications to either register a product on the ARTG or apply for an overseas alternative to be supplied. So we have got some limitations in that regard within the TGA, but we're certainly progressing reforms within the scope of our remit.

Mr Henderson: I mentioned earlier today that we've also formed what we call a medicine shortage stakeholder forum, with 40 organisations across health professional representative groups, consumer groups and industry, for example. I did take on notice, from Senator Steele-John, to provide a list of those organisations as well. We are looking at where we can continue to make improvements to our processes and communication. So we're really looking to utilise that group, ongoing, to provide that insight.

Senator PAYMAN: That's great to hear. Medicines for things like diabetes, menopause, rheumatic fever and breast cancer are among those that have been affected by the shortages this year. While the health minister can approve similar medicines for use during a shortage, a constituent of mine named Joanne told me that these are often difficult to find, as a shortage of one type of medicine can lead to a rush on approved alternatives. So what action is the government taking to, hopefully, address that problem?

Mr McIntyre: Perhaps I can come in here. I look after the PBS elements of shortages. There are a range of things associated with the management of medicines that we do, to try and help with situations where medicines are in tight supply. The TGA has a monitoring process, and that includes reporting that can help understand whether things are in acute shortage or whether the supply is tight. Where it's tight, we have a number of mechanisms to try and ensure that the medicines that are available can be distributed as broadly as possible and minimise those knock-on impacts to other therapies. The most important of those are probably the minimum stockholding requirements.

For a wide range of the medicines that are on the PBS, the sponsors are obliged to maintain a six-month supply of availability in-country, and, where they're unable to do that, they have reporting obligations to advise us. We can then work with them and with other sponsors to communicate the supply tightness and ensure equitable distribution. We also have new arrangements that have been put in place with wholesalers, with an agreement that we signed with pharmaceutical wholesalers last year that obliged them to manage the supply, such that there can be equitable distribution when supply is tight. This is, if you like, the toilet-paper-shortage problem, where there is enough but everyone puts a rush on it at the end. What can happen is that the big players, which are often in metropolitan areas, get everything they need, and the little players, who tend to be small pharmacies and remote and rural, are the ones that miss out. So we work with the pharmaceutical wholesalers to ensure that some supply is held back, to be made available to those that might need a smaller amount of supply.

We also work closely on particular issues of shortage. IV fluids are an example where the minister made announcements last year, and a company that manufactures in Australia has ramped up their production of IV fluids onshore so that we can make sure that the supply tightness there can be met. Onshore production is often not possible, but, where it is, it's certainly one of the options that we discuss with wholesalers and potential pharmaceutical sponsors. I'll leave it there, but there's a lot more about all of those items.

Senator PAYMAN: On the six-month supply, does that apply to alternatives as well, or is that just—

Mr McIntyre: We have what we call designated brands, and they're the ones that have that obligation. So it's not all medicines on the PBS, but it is usually those that are significant and whose shortages would cause concern

for patients. Of course, there are situations where, at the time of listing, supply is very tight for pharmaceuticals, and what we don't want to end up doing is causing a shortage by requiring stockpiling. So we sometimes have to manage that obligation closely with ensuring continuity of supply.

Senator PAYMAN: A report from the Institute for Integrated Economic Research found that Australia imports more than 90 per cent of its medicine. The local manufacturing sector is small, but the Royal Australian College of General Practitioners suggests that further investment in domestic medicine production could help to address shortages and hopefully avoid the toilet-paper situation. Will the government invest in domestic production of medicine to help those Australians affected by shortages?

Mr McIntyre: Certainly the Australian government considers all options to address medicine shortages. There's a very wide range of medicines, and one of the unfortunate things about medicine supply chains is that they're all quite different from each other. Many medicines have a primary ingredient that is only made in one place in the world, and so Australia, alongside many other countries, has to deal with these supply chains flexibly. While Australian manufacture is sometimes a good solution, it often isn't. IV fluids are an example where that proved a useful solution, but that's partially because the fluids are heavy, because they're mainly water, and therefore local production leads to benefits. For many other medicines, the benefits are more modest and the challenges associated with getting the materials to manufacture here wouldn't necessarily best mitigate the risk and might make the medication much more expensive for Australian patients.

We continue to work with sponsors. It's always going to be a challenging situation, and there are, at any one time, a number of shortages. But the data shows that, over time, we tend to resolve some shortages and new ones arise and that the same things don't remain in shortage for long periods.

Senator Green: Senator, can I give you a nuanced answer—

Senator PAYMAN: Of course.

Senator Green: just to say that the government does want to grow medical manufacturing, and, although it's not part of this portfolio, of course, you would be very well aware that the National Reconstruction Fund has a targeted investment towards medical manufacturing. That's part of our Future Made in Australia policy. I think Industry might be on today somewhere else; I've lost track of which committee is on which day! But that is part of the work that we're doing in manufacturing, although it's a very nuanced policy, as our officials have explained to you.

CHAIR: I do need to share the call now.

Senator PAYMAN: Those were all my questions. Thank you so much; I appreciate it.

CHAIR: Senator Barbara Pocock.

Senator BARBARA POCOCK: My questions are in two lines. One is for the Australian Institute of Health and Welfare, in relation to homelessness, and the other is in relation to LGBTIQA blood donations. I'm going to be quick; I've got 10 minutes and the iron fist of the Chair in charge. So if I can have the homelessness question, I'll start now. It's simple, but I'm sure not a simple question to answer in total. Does the Commonwealth know how many people are experiencing homelessness in Australia right now?

Dr Bolevich: The institute does provide regular reporting on homelessness, and we have indeed recently provided reports on the current state of homelessness in Australia. I haven't got the particular number in front of me that you are asking about, but we can certainly provide it to you on notice and it is available on our website as well.

Senator BARBARA POCOCK: Okay. Thank you. If you could, make the number available. What data do you rely on? How do you determine that figure?

Dr Bolevich: Most of our data is actually collected from the specialist homelessness services. We have a very good data collection system that was established a few years ago, where providers of specialist homelessness services regularly—on a weekly and monthly basis—provide us information on their activity, on the services they provide to people experiencing homelessness right across Australia. We largely base our reporting on the information that is directly collected from that sector.

Senator BARBARA POCOCK: I think of my own state. There are a range of very diverse, sometimes very small and sometimes quite large services that assist people who are without homes. How do you collect that data? You have a system where they complete a form that's comprehensively and consistently applied across the very diverse range of services, including in regional Australia?

Dr Bolevich: Yes, indeed. Obviously, the first task for the institute in that process some years ago was to establish some data standards, which is what we usually do very well, in consultation with our state and territory

colleagues and the sector. Once that standardisation process is complete, there is usually then a phase of developing systems for data collection. This one is fairly well-developed now and is supported by a specialised IT agency that specialises in working with this sector. Some providers have their own systems that they have adjusted to be able to provide the minimum data set. Others rely on a more generic product, let's say, especially smaller providers. They just log onto the website provided by the site, the organisation, and provide us the data that way.

Senator BARBARA POCOCK: Can you summarise in 30 seconds the trend of what you're seeing over time?

Dr Bolevich: I would prefer to provide you more accurate information based on our reports, as I said earlier, if that's okay.

Senator BARBARA POCOCK: Let me just check then. How does your data line up with the ABS data, where we have it? For example, the census in 2021 would be the last one, I imagine.

Dr Bolevich: I might just check with the deputy CEO whether she has any insights on—

Senator BARBARA POCOCK: If you want to, take that on notice if it's too tricky.

Ms Gates: I can talk to that. As Dr Bolevich outlined, we collect most of the information on the use of homelessness services as opposed to the number of people who are homeless, whereas the ABS, as part of their census, collects data on the number of people who are homeless.

Senator BARBARA POCOCK: How did the figures compare?

Ms Gates: The number of people who receive homelessness services is obviously determined by those people who approach homelessness services, as opposed to all of them. I haven't got the two numbers in front of me to explain those.

Senator BARBARA POCOCK: Could you provide those on notice over time, say over the last five years? Well, you'll only have one census point, but, if you could give me the trend and the comparison, I'd appreciate it. A 2024 investigation into Australians experiencing homelessness found that the average age of death for people without housing was 44. That's 30 years younger than the average life expectancy of the broader population. Do we know, or do we have any data on, how many people die with a recent experience of homelessness?

Dr Bolevich: We have in recent months produced a report based on a linked data set where specialist homelessness service data was linked to mortality data in order to produce the estimate that you have just referred to. Again, we'd be very happy to try and provide you that data more accurately.

Senator BARBARA POCOCK: Thank you. I apologise for not being more familiar with your website. What proportion of those who receive a homelessness response or support through the Commonwealth specialist homelessness services funding remain homeless after they have received that service? Can you tell me that?

Dr Bolevich: Again, we would have to provide that to you in writing.

Senator BARBARA POCOCK: You have that data though?

Ms Gates: We do have it.

Senator BARBARA POCOCK: You've got evaluations of what happens?

Dr Bolevich: I think we do, yes.

Senator BARBARA POCOCK: Okay. Thank you. I look forward to getting all of that information, and I appreciate the work that you're doing.

Dr Bolevich: We'd be happy to provide that.

Senator BARBARA POCOCK: Can I go, then, to the question of blood donations. It is welcome that the Therapeutic Goods Administration has given Lifeblood the green light to collect plasma and whole blood from gay men and bi men and trans women who have sex with men without an abstinence period. However, the way this is being implemented raises some questions for constituents. First, why has plasma donation been introduced without whole blood donation?

Prof. Platona: On 14 July, Lifeblood launched the plasma pathway following the TGA's approval on 25 May 2023. The deferral, like you said, means that gay and bisexual men, transgender women and other groups are eligible to donate plasma for fractionation into medicine with no wait time by CSL Behring. Extensive research and modelling have demonstrated that changes could be implemented without compromising the safety of Australia's blood supply. Plasma was the first pathway to be adopted—approved and adopted—because plasma for fractionation undergoes pathogen inactivation, a process to eliminate or inactivate viruses and bacteria to ensure the safety of plasma for fractionation. The TGA is here. They have approved it, and they have more technical details.

Prof. Lawler: Thank you. I don't have a great deal to add. In a sense, the regulation of blood supply mirrors that of therapeutic goods. There is always an appropriate balance between access and risk. We recognise that the introduction of the plasma pathway is a significant step forward, and we've obviously worked with Lifeblood on that. As Ms Platona has highlighted, the risk can be mitigated on the plasma pathway because there are the pathogen inactivation steps, and that means that because those are not usable in the whole blood stream then other risk mitigation measures need to be employed.

Senator BARBARA POCOCK: Do you have a timeframe for whole blood donation?

Prof. Lawler: That would be a matter for Lifeblood to submit to us to have that considered.

Senator BARBARA POCOCK: Have you asked for that? Have you requested any information? Have you got a plan at all for working with them?

Prof. Platona: The process is that Lifeblood makes applications to the Therapeutic Goods Administration. The TGA assesses and makes a decision on whether it is approvable or not, and then it comes back onto Lifeblood for proposals on implementation timelines and so on.

Prof. Lawler: It would depend, Senator, if I may, on Lifeblood bringing to us a proposal that provides the same risk management assurance that the pathogen inactivation steps do for plasma.

Senator BARBARA POCOCK: My next question may be more appropriate for Lifeblood, but I'm sure you'll tell me. Why do the whole blood questions proposed by Lifeblood not meet the standards set in comparable countries like Canada, the UK and the US? In particular, advocates have expressed concern about the proposed question about being monogamous for six months. Six months is, I'm told, an unnecessarily long deferral period. The question could create confusion and is superfluous because subsequent questions about anal sex and three months of monogamy are the ones that matter. The questions asked in Canada, the UK and the US are simple, easy to understand and medically justified. Why are Lifeblood's proposed questions different to these? Are you able to help me with that?

Prof. Platona: If you would like, we'll take the question, and I can raise it in our regular meetings with Lifeblood. We can come back to you in writing with what their response is and comparison with other countries.

Senator BARBARA POCOCK: Great. Thanks very much. I really appreciate your assistance.

CHAIR: Great. Senator Ruston.

Senator RUSTON: I'm just finishing up on the proton therapy. Minister, can you guarantee that Australian children, who are the predominant beneficiaries of proton therapy, will get access to proton therapy treatment in Australia and, if so, when?

Senator Green: As you can see, I've just joined the hearing. I'm not really aware of the questions you were asking before the break. I might ask the officials to answer your question, and if I can get you any further advice I will.

Senator RUSTON: That would be great.

Dr Develin: I think it remains the intention of the Australian government to establish a proton beam therapy service in Australia. You are right; I think it is about two-thirds of patients identified for proton who are likely to be paediatric patients.

Senator RUSTON: So there's no timeline as far as the federal government is concerned? It's pretty much left in the hands of the South Australian government?

Dr Develin: At this stage, we are still in discussions with the South Australian government.

Senator RUSTON: Have you spoken to the South Australian government since the correspondence from Minister Koutsantonis in July?

Dr Develin: Yes, we have. We are in regular communication with our counterparts in the health department.

Senator RUSTON: Can you divulge what those communications are leading to? I mean, is the intention of the federal government to work with the South Australian government and provide the additional funding for this to actually occur?

Dr Develin: That will obviously be a decision for government. The nature of the conversations we've had with our counterparts has been to understand the information they have provided us, the additional analysis and the reports they have done so that we can inform the Australian government's decision.

Senator RUSTON: Can I move on to the response that you provided me just before the break, Mr Comley, in relation to the website. I want to clarify part of the department's earlier testimony where it was said, 'The

campaign website was not active during caretaker period.' However, you've advised in your communication that the URL was live until August 2025. I wonder whether you want to correct the record.

Mr Comley: I'm just waiting for Ms Balmanno. I'm not sure where she is.

Senator RUSTON: While we're waiting for Ms Balmanno, could I ask who ultimately makes the decisions about changes to DPA areas.

Mr Comley: I'll get the relevant officers on DPA areas.

Senator RUSTON: Regarding the 17 new DPA areas, I'm wondering who made the determination or who decided on the 17 locations.

Ms Strapp: The minister agreed with it. It's generally a yearly process we do with data as we update DPA based on our new statistics. We provide advice to the minister on where the boundaries have moved or the statistics have moved, and he makes a decision on the application of that.

Senator RUSTON: Is it possible for the department to table the advice in relation to the DPA changes? You can take that on notice.

Ms Strapp: I'll take that on notice.

Ms Shakespeare: Senator, ordinarily, no. I don't think we'd provide advice. We can confirm that advice was provided and the dates on which we provided it, so we're happy to do that.

Senator RUSTON: If it is at all possible, could you actually provide the basis on which the determination was made. Were any of the locations that were recommended by the department for change rejected by the minister?

Ms Strapp: No. We provided a list of the updated DPA under the methodology that we use to update DPA. It's the same methodology we use every year when we update it.

Senator RUSTON: That's fine.

Ms Strapp: Yes. That's it. We just provided that, and those were the 17 areas. Those were just the areas that were having upgraded DPA or going from non DPA or partial DPA to full DPA.

Senator RUSTON: So the 17 areas were recommended by the department. The minister had no idea or understanding as to that? It was just purely based on the statistical analysis that you'd done.

Ms Strapp: Those 17 areas, yes.

Senator RUSTON: So there are no other areas that have been included in DPA that the department didn't recommend?

Ms Strapp: There is a process where we look at exceptional circumstances, and that's based on recommendations from our distribution working group. There may have been—I'm just trying to recall whether there were—outside of this process, other areas that were made DPA based on that advice. But, in terms of that process that you're talking about, it was only those areas that were identified through data that were made DPA status or upgraded from partial to full DPA.

Senator RUSTON: If you could provide some further information about the processes around those DPAs, distribution priority areas originally had a purpose, and it appears to have been quite significantly eroded by the changes. But thank you for your advice, Ms Strapp. Do we have the website people? Thank you. Before you came in, I just wanted to clarify something. I'm not sure, Ms Balmanno, whether it was you that said it, but one of the officials said, 'The campaign website was not active during caretaker period.' However, the piece of advice that the secretary provided me just before we broke for afternoon tea quite clearly states that the URL was live until August 2025. I just wonder whether you wanted to correct the record.

Ms Balmanno: The campaign content on that site was taken down; the URL was still live. So it's all actually on the health.gov site. It's one big website.

Senator RUSTON: You said the campaign website was not live, and it was.

Ms Balmanno: I'm happy to correct that to say that the campaign content, which we refer to as a subsite, was removed.

Senator RUSTON: Why wasn't the website taken down in December 2024, when you said the campaign advertising ended?

Ms Balmanno: At that stage, in terms of the actual advertising ended, there were still public relations activities as part of that campaign that went into 2025.

Senator RUSTON: I understand, from this information you've just given me, that the content on the website was reviewed, given the election was called and as a result of the department updating the content. I'm keen to

understand, given that the department content cannot be political, why the department renamed its website to 'Strengthening Medicare' after the election was called when that was the election slogan of the Labor Party. I will table this.

Ms Balmanno: 'Strengthening Medicare' was the name of the budget measures that were announced in the 2025-26 budget that were the content of the campaign. So, in the post-budget update to the site, that's when it was labelled to 'Strengthening Medicare'.

Senator RUSTON: Do you really expect people to believe that you had a name on your website up until caretaker mode that came into effect that was different, and then, on the day the election was called, you changed the name of your website to 'Strengthening Medicare'? And I table this, Chair. It is exactly the same as the campaign slogan of the Labor Party's election campaign, so I'll just table that.

Ms Balmanno: 'Strengthening Medicare' appears throughout the budget materials that were released some weeks prior.

Senator RUSTON: I struggle to accept the fact that it was so unbelievably coincidental that that was the day you chose to change your website to have that as the banner on it. Could I quickly ask some questions around mental health and particularly suicide prevention research? What's the status of the National Suicide Prevention Research Fund as we sit here today? Is it receiving ongoing funding?

Mr Matthews: For the national suicide research fund, I think, funding of $4 million over two years was announced. I forget the date. It was probably about a month or so ago. Ms Price might know the exact date for that. That will give the funding for the next two-year period. We'll be working through with Suicide Prevention Australia to put the agreement in place to cover the arrangements for that funding for the two-year period.

Senator RUSTON: Why only for two years?

Mr Matthews: The two years really just gives enough certainty for the research and the aim. There is also a small allocation of funding to do a fairly rapid review of the research function that will inform then the longer consideration of how that research then might be set up as a longer term piece of work. That will obviously be informed by the broader suicide prevention strategy that's there, as well as the future directions of the National Suicide Prevention Leadership and Support Program as well.

Senator RUSTON: So you contend that this additional funding that came very late—in fact, after the original funding had expired—is sufficient to maintain the continuity of that research project given the incredibly high incidence of suicide in Australia? Maybe that's one for the minister. Do you think it's adequate, Minister?

Senator Green: Sorry, I didn't get the first part of your question.

Senator RUSTON: You can just answer the last part, if you like.

Senator Green: Could you repeat the question? Thank you.

Senator RUSTON: Do you believe that the $4 million that was very belatedly provided to support the national suicide research fund is adequate to maintain the continuity of research that is needed for this very important project that has been ongoing? Funding was uncertain, and now we've had an ad hoc top-up of $4 million over two years. I'm just wondering whether you think that is adequate.

Senator Green: It's a really important program, and that's why we funded it. It's why we're delivering $361 million over four years for our new mental health services in a stronger Medicare package, a number of different measures that we're taking in regard to mental health. Of course, as you know, with any measure that does have an end date, we'll consider those fundings through regular budget processes.

Mr Matthews: I would note that I think the amount that is funded over the two years, $2 million per year, is also consistent with the funding. It was funded before at that level as well.

Senator RUSTON: Yes, for five years.

Mr Matthews: Yes.

Senator RUSTON: Five years gives some sort of certainty and runway; two years is a much shorter period of time.

Mr Matthews: The intention is to provide enough certainty for the research to continue while there is a rapid review done to look at how it might be set up longer term and how that relates to broader research efforts through the MRFF and those wider research efforts as well so that we can have a look at it a little bit long term and make sure it is fit for purpose over the long term.

Senator RUSTON: Minister, recent data from the Productivity Commission showed that the number of Medicare clients for Medicare subsidised mental health services was at its lowest level in a decade. I'm interested

to understand whether your government still stands by its decision that cutting in half the number of Medicare subsidised mental health sessions would increase the number of people who were able to get access to these sessions.

Senator Green: I can get officials to talk you through that decision. I'm sure you've ventilated it in many sessions in these estimates before, but we can talk about the reasoning behind that decision again, if you like. What I would say is that we are investing $361 million in mental health over a number of different programs, and the drop in that number might not necessarily relate to that decision, but I'm sure officials can clear that up for you. Of course, we've also opened 40 Medicare mental health centres where you don't need anything other than a Medicare card to see the mental health professionals that you need.

Senator RUSTON: I'm keen to understand this Better Access program. We heard on Tuesday morning from the RACGP *Health of the nation* report that found that 71 per cent of GPs said that mental health is the top reason for patient visits, and so we still have this legacy of the sector calling out for the reinstatement of Medicare subsidised mental health sessions. Is the government or the department doing any work to ascertain the effectiveness of its decision to reduce or cut those services in half?

Senator Green: I will let officials answer about the work that we're doing. Obviously, the Better Access evaluation found that providing additional services to existing customers limited the capacity of providers to offer treatment to new users, with many people from lower socioeconomic backgrounds and regional and rural areas missing out, but I can let officials give you a more fulsome answer.

Mr Matthews: This has probably been covered in estimates a few times previously, but the number of people claiming 20 sessions was quite low. I think the number up to 20 was only about 1½ per cent or so.

Senator RUSTON: Mr Matthews, I didn't ask you about that. I actually asked you if you were researching the effectiveness of the decision.

Mr Matthews: Yes, we'll be monitoring the data. I'm trying to answer. We will be watching the data. What we do know is from the point of comparison back to 2022, because the debate is obviously there's a capacity there of the service to provide it. So, if people are having more sessions than that, then that restricts the number of people that can come into that capacity. What we have seen is that in 2023 there were 45,000 additional people compared to 2022 that had taken up some component of the initial 10 sessions, and then in 2024 there were 54,000 additional people compared to 2022 who had taken up some component of that initial 10 sessions. So we have seen an increase in people that have accessed the 10 sessions under the Better Access scheme from the point of that decision.

Senator RUSTON: So you're saying that the Medicare figures that say that people accessing the Medicare subsidised mental health services are at the lowest level in a decade are incorrect?

Mr Matthews: No, I'm not saying that at all. The broader, in totality MBS data for Better Access, which obviously is a demand driven program, has a range of factors in there. I'm not saying that that's increased. I think the data shows that it probably has gone up through COVID, and then it is lower, and then it dropped down a little bit. I think it might be up a little bit in the last year, but there has been some sort of reduction. But also, comparing it to through the COVID period, it's not necessarily clear whether that's associated with the additional 10 sessions in any way. In fact, we have seen those increases in the initial 10 sessions.

Of course, the Better Access scheme sits in the totality of mental health, and there has been the increase in the others, seen through both the headspace centres and the Medicare mental health clinics and other channels to come in for mental health. And then we'll soon have the National Early Intervention Service as another pathway in there. So it isn't the only pathway through for people from a mental health point of view either.

Senator RUSTON: I look forward to seeing that information and data. I'm assuming it will be publicly available. Have I got one second to ask Ahpra, or have they gone? If they've gone, I'll put it on notice.

Senator Green: I don't think they've been dismissed yet, so I think that's in your hands.

Senator RUSTON: I wasn't sure; maybe I had said it.

Australian Health Practitioner Regulation Agency

[17:12]

Senator RUSTON: I just quickly wanted to touch on influencers on social media in relation to cosmetic procedures. It's interesting that both the TGA and the government expressed concern at this rising issue. Do you share those concerns?

Mr Untersteiner: Yes, I do. We've seen, both in terms of cosmetic surgery and cosmetic procedures, a rise in the use of social media for advertising and the use of influencers. We have now provided an updated guidance,

both for cosmetic surgery and for cosmetic procedures, which prohibits certain types of advertising, particularly when it relates to influencers. We have been now undertaking social media audits to identify breaches of the advertising guidelines, and, in fact, we have been launching a new technology which better identifies earlier those sorts of breaches.

Senator RUSTON: Do you have any data from those searches you've done that you could make available?

Mr Untersteiner: I can certainly get that for you. I don't have it on me, but I'm happy to take it on notice.

Senator RUSTON: Do you consider that the current regulations for the advertisement of cosmetic procedures are fit for purpose in the modern context of social media?

Mr Untersteiner: I do. Again, if I draw a distinction between cosmetic procedures and cosmetic surgery, we've only just released our guidance on cosmetic procedures very recently. In fact, it only came into force in September, so it's still relatively new. But, again, we believe it's immediately having an impact. And again, from a risk management perspective, we've done a lot of work to advertise that new guidance and to try and encourage compliance with the guidance. But, as we move forward now, we're taking firmer action.

Senator RUSTON: I understand it's only been in for a very short period of time. Maybe for next time, I'd be really interested to understand, after you've got an understanding of the impact of the new measures, what actions you're proposing to take in order to make sure that the regulations are enforced.

Mr Untersteiner: Sure, I'm happy to do that.

CHAIR: We will now be moving to outcome 3, Ageing and aged care, and programs 3.1, 3.2 and 3.3. For the purposes of Hansard, we will be releasing the following agencies from outcome 1: the Australian Health Practitioner Regulation Agency, the Australian Institute of Health and Welfare, the Australian Radiation Protection and Nuclear Safety Agency, the National Blood Authority, the National Health Funding Body, the National Health and Medical Research Council, the Office of the Gene Technology Regulator and the Organ and Tissue Authority.

Department of Health, Disability and Ageing

Aged Care Quality and Safety Commission

Independent Health and Aged Care Pricing Authority

Office of the Inspector-General of Aged Care

[17:19]

CHAIR: Welcome to outcome 3, Ageing and aged care. I'm going to start the questions if I can. Earlier on today, the department tabled some data to the committee. Based on that data, can somebody tell me how many individuals are on the national prioritisation system?

Mr Pugh: Thank you, Senator, for the question. As at 30 September 2025, there were 121,909 people on the national prioritisation system waiting for a package at their approved level.

CHAIR: Great. Thank you, Mr Pugh. I understand there are some caveats to this data. Can you please explain those to me.

Mr Pugh: I am happy to. I mentioned this at the aged-care service delivery inquiry as well. We have an aged-care data warehouse. Out of that data warehouse, we're able to pull data at any point in time. However, we go through a series of verification, validation and quality assurance processes before that data is published. It was quite clear through that inquiry process and also at previous estimates that we have form for providing that data as recently as we can. So, although that data has been provided, those caveats remain attached.

CHAIR: Great. Thank you. Why is the demand for in-home care so high currently?

Mr Pugh: The demand for in-home aged care is so high at the moment for a couple of reasons. One is that we obviously have an ageing population, and we know that people want to get into care and receive access to the services that match the level of need that they have. So that's what we are aiming to do through the Home Care Packages Program as well as through the Support at Home program, which will commence from 1 November 2025.

CHAIR: Great. As of 30 September's data, how many older Australians have access to a home-care package? Presumably that number is equally high.

Mr Pugh: Sorry, can you repeat the first part of that question.

CHAIR: Yes. As of the 30 September data, how many older Australians have access to a home-care package?

Mr Pugh: Thank you. As at 30 September 2025, there were 310,363 people who had been allocated a home-care package. Of those, 296,852 people were in an actual home-care package receiving care.

CHAIR: Great. Thank you. On 3 September, Minister Butler and Minister Rae announced an additional 20,000 home-care packages that would be released prior to 31 October 2025. How many packages have been released so far?

Mr Pugh: As of today, 10,001. They've been released in almost equal tranches over the last three weeks, and there are three weeks to go before commencement. So we will continue with that cadence.

CHAIR: Great. What happens post November 1, and how many packages will be rolled out between now and 30 June 2026?

Mr Pugh: Between 1 November and 31 December 2025, there will be an additional 20,000 packages rolled out as part of the Support at Home program. From 1 January to 30 June 2026, there will be an additional 43,000 packages rolled out under the Support at Home program.

CHAIR: Great. Thank you. I'm going to hand the call to the deputy chair.

Senator ALLMAN-PAYNE: What is the current timeline and milestone plan for CHSP integration into Support at Home, and what risk assessment has been done to ensure continuity of meals, transport and social supports?

Mr Pugh: The government has announced that the Commonwealth Home Support Program will not roll into the Support at Home program any earlier than 1 July 2027.

Senator ALLMAN-PAYNE: I'm aware of that.

Mr Pugh: So, between now and then, all current services remain operational, so access to those services remains operational, as I said. In terms of the milestone plan, that's currently something that we are working through. We would do that through advice to government but also with a deep level of consultation with the sector and with other affected parties.

Senator ALLMAN-PAYNE: Do you have a timeframe for that milestone plan to be completed by?

Mr Pugh: Not at this stage.

Senator ALLMAN-PAYNE: Has the department modelled the impact of closing CHSP on demand for Support at Home in 2027? I did ask this question on notice at the inquiry and didn't get a—

Mr Pugh: Not specifically at this stage. That will form part of the milestone plan that we just talked about as well.

Senator ALLMAN-PAYNE: What consideration has been given to the expected closure of the CHSP in 2027? Is it confirmed that the program will be closing then?

Mr Pugh: Going back to my previous statement, government has announced that it will not roll into the Support at Home program any earlier than 1 July 2027.

Senator ALLMAN-PAYNE: I guess the question is that providers and older people need certainty. We've heard at the inquiry that we've already got providers who are exiting CHSP because they've said there is no certainty. I think you'd have to agree that saying it won't close before a date is not clear. So has the department made a recommendation to the minister or the government around whether funding will continue past 1 July 2027?

Mr Pugh: No.

Senator ALLMAN-PAYNE: Is the intention—

Ms Atkinson: Sorry, I could add an addendum to that. The funding will continue. The government has not made an announcement on the form in which it will continue, beyond that it will not roll into Support at Home sooner than 2027.

Senator ALLMAN-PAYNE: So is the intention, once CHSP is rolled into Support at Home, that everyone who is currently supported through CHSP will go on to a Support at Home package? So that's all 800,000 people that are currently on CHSP?

Ms Atkinson: The details of exactly how that will work are to be determined and will be considered by government.

Senator ALLMAN-PAYNE: In the budget, it looks like there's no additional funding for additional Support at Home packages beyond the 83,000 coming in the financial year to the middle of next year. Is that correct?

Mr Pugh: That is not correct. In the MYEFO context last year—I'll have to get the exact figures—there was a $4.2 billion announcement around the funding for the Support at Home program over the forward estimates period.

Senator ALLMAN-PAYNE: How many packages in total would that cover, and roughly how many per year?

Mr Pugh: I'll give you the answer for the first year of the operation of the Support at Home program. That will cover the 320-odd thousand people who will transition from the Home Care Packages Program into the Support at Home program.

Senator ALLMAN-PAYNE: Sorry, is that people who are currently on a home-care package that transition across?

Mr Pugh: It will be by 31 October. So that's the 320-odd thousand plus the additional 63,000, which is the 83,000 that I mentioned before minus the 20,000 that have already been rolled out.

Senator ALLMAN-PAYNE: Yes. My question is: is there any additional funding provided for, beyond the additional 83,000 and the people who already have a package and who are coming across?

Mr Pugh: Yes, we have an appropriation for the forward estimates period.

Senator ALLMAN-PAYNE: Roughly how many packages will that cover?

Mr Pugh: Over the next 10 years, we'll be funding an additional 300,000 places—so by 2034-35.

Senator ALLMAN-PAYNE: So it's roughly 30,000 a year?

Mr Pugh: Roughly 30,000 a year.

Senator ALLMAN-PAYNE: But we currently have a waitlist of 200,000.

Mr Pugh: No, we have a waitlist of 121,000 on the NPS.

Senator ALLMAN-PAYNE: And the 100,000 or so who are waiting for an assessment.

Mr Pugh: Yes. Well, Ms Blackwood might like to provide some additional context around those data points when she comes to the table. I'm sure she will come to the table later on in the session.

Senator ALLMAN-PAYNE: Okay. I note your evidence that it's roughly 30,000 packages a year for the next decade. Professor Kathy Eagar, who is a former adviser to the royal commission, has forecast the demand for Support at Home, and she said that without more packages—so more than 30,000 a year—the majority of seniors will be denied home-care support in five years. Is she right?

Mr Pugh: That is not my understanding. What we have modelled and what we have funded is that number of packages entering the system, and that's predicated on an average three-month wait time to receive access to services by the end of the second year of the Support at Home program.

Senator ALLMAN-PAYNE: So your modelling shows that everybody who's applying for a package will only wait three months by the end of that period in a decade?

Mr Pugh: No, by the end of the second year of the Support at Home program. That is the government's commitment at this time.

Senator ALLMAN-PAYNE: So what is the plan to get the wait time down to three months?

Mr Pugh: Well, we'll be rolling out those additional packages. To your earlier point, there will be some improvements made, and we're already seeing positive trends in terms of assessment data, so those volumes are being pushed through the system at a more rapid pace.

Senator ALLMAN-PAYNE: Does that account, then, for the 800,000 or so people who are currently on CHSP who would also have to transition across to Support at Home? The reason I ask that question is that Professor Kathy Eagar has also said that it's not going to be possible to hit your waitlist target while also closing CHSP and transporting those 800,000 across. I note that you said you haven't done any modelling on closing it, so I'm wondering how the department are sure it's going to hit their target if those 800,000 people are transitioning across.

Mr Pugh: We modelled based on the assumption that they would all be in the program from that point in time.

Senator ALLMAN-PAYNE: It's modelled on 800,000 people on CHSP coming into the program in 2027?

Mr Pugh: That is my understanding, yes.

Ms S Stewart: I wanted to add something to Mr Pugh's response. I completely understand that we're focused on an aspect here, which is the waitlist, but I think it's also important to give the context of overall reforms. The

packages, the rollout and the Support at Home are one aspect of that and a very important aspect of that. I think it's also important to note that the government has made a commitment around strengthening Medicare and access to GPs for older people when they need that sort of assistance. There's a complete change in the way that people get assessed in the system. There's a single point of assessment. There are also changes to the tool that's used and changes and improvements in the workforce, standards and quality. I think it's important in terms of that overall context that what we're seeing is huge reform across the whole system. We have done that modelling, and it is about meeting that commitment two years after the Support at Home program starts on 1 November.

Senator ALLMAN-PAYNE: I'm somewhat confused by the fact that, when we asked the question in the OPD about whether you'd done modelling on CHSP closing, the answer was no, but now I'm hearing that there's modelling that has been done and takes into account the 800,000 from CHSP going into the other program. That's why I'm confused. If you could un-confuse me, that'd be helpful.

Mr Pugh: I can probably correct the record there. We've obviously done a lot of modelling around a lot of different options. The government hasn't made a decision on what the final transition of the CHSP into Support at Home will look like and at what date.

Senator ALLMAN-PAYNE: I'm just trying to make sure I understand, because I don't want to be going off wrong information. If you're telling me that you've modelled a range of scenarios but the government hasn't decided yet what's happening with Support at Home, how does the answer you gave me earlier about 300 current packages that are already out there plus 30,000 a year account for everybody including the 800,000 who would be coming from CHSP to Support at Home?

Ms S Stewart: I think there's an opportunity to talk about the sequencing here. The commitment that has been made around the average time to wait is around the Support at Home program two years after it starts. The other commitment is around the CHSP, which is a bulk of older people living in Australia. They would start to transition and move into that program at that date. I think that there's a sequencing thing, and Mr Pugh is correct in that we haven't done the modelling of that. We've got to be doing the planning for that. The focus of this is the Support at Home program, which starts on 1 November this year.

Senator ALLMAN-PAYNE: Just so I'm fully clear, they're two separate things, and, right now, the modelling that you have done on getting down to your wait times et cetera is only on the 300,000 who are going to transition across to Support at Home—they currently have home-care packages, and they're transferring across—plus the additional 30,000 that are going to roll out every year for a decade. And, in terms of the 800,000 who are currently sitting on CHSP, there hasn't been any modelling done yet, so it wouldn't be possible to answer a question around how that will impact wait times for Support at Home if they are all rolled into Support at Home, because that hasn't been done yet.

Ms S Stewart: The modelling hasn't been done, although—there might be others in the room who are able to speak to this—there is an assumption and understanding that that cohort tend to be lower level users in terms of where they might go into that system, in terms of those packages.

Senator ALLMAN-PAYNE: We did hear at the inquiry that there are large numbers of CHSP providers who are supporting people with much higher needs because they're waiting for their home-care package. I think I understand where that's at now. Do you have any specific initiatives that are funded to recruit and retain CHSP staff in rural and regional areas, including travel or training incentives? If the answer is long and lengthy, I'm very happy for you to take it on notice. But I'm keen to know if you have some broad details now. You could give me more detail on notice.

Senator Green: We have time for that information, Senator.

Ms Harper: It actually is likely to be quite a long and lengthy response, which we are more than happy to provide extensive detail on. I might ask my colleague, Ms Milfull, to talk in a moment about some of the focus on rural and remote areas, in particular, but we do have broad-reaching initiatives that target access, not only to training but also to recruitment and retention in rural and remote areas.

We also have a continued focus on encouraging, where possible, direct employment of workforce in those areas. We are seeing really positive trends in terms of direct employment more generally, which is fantastic because obviously it reduces those expenses for providers and, really importantly, ensures that connection to older people and the continuity of that relationship. We do note that, particularly in those very rural and remote areas, there are real challenges, and we see that proportion of direct employment really drop off.

It's a consistent focus of training, incentivising and encouraging local community members to take on board a role in aged care—whether or not that's starting in a more junior position and advancing to a more senior

position—and really ensuring that there's a pathway within communities. The other comment I would make is that I'm very happy to step this out for you in quite some detail because there are a lot of programs that cover off—

Senator ALLMAN-PAYNE: I'm happy if you can give me on notice what they are, rather than take up time now.

Ms Harper: No worries.

Senator ALLMAN-PAYNE: Is there anything that you want to add, Ms Milfull, in a summary, before you take the rest on notice?

Ms Milfull: Yes, we're very happy to give you a detailed list. I think I would just add that the government is continuing to invest heavily to support service delivery in rural and remote areas, including workforce supports. I wouldn't say it was necessarily specific CHSP initiatives, but we have very specific programs. For example, we've got the Regional, Rural and Remote Home Care Workforce Support Program to attract 4,000 more home-care workers, the Rural Locum Assistance Program and Indigenous Employment Initiative Program. So there are a number of things which go to the workforce measures that Ms Harper was talking about.

Alongside the broader Support at Home reform work, we're also, as part of Thin Markets Branch, doing a lot of work looking at the longer term, at the policy settings that will actually identify any remaining gaps in regional, rural and remote aged-care policy, particularly as the changes come in on 1 November. You might be aware that we're reviewing, for example, the MMM—the remoteness classification system—and we're now working to develop a regional, rural and remote aged-care framework and work plan. So, if we feel that there are gaps that still need to be addressed to make sure that those supports are targeted, we've got a plan to move forward with that.

Senator ALLMAN-PAYNE: Great, thank you. If there are any programs that specifically target CHSP or include CHSP, could you make that clear in your response on notice?

Ms Milfull: Sure.

Senator ALLMAN-PAYNE: Thank you, I appreciate that. I just want to go to issues around co-payments with Support at Home and the safety net. How were the percentages for co-contributions for those co-payments calculated? I'm particularly interested to know who did the work. My understanding is that it wasn't the taskforce. Was it the Treasury? Was it cabinet? Who did that work?

Ms Trainor: The Aged Care Taskforce made conceptual recommendations at a higher level around services classifications. They made the specific recommendation around clinical care being fully funded by government, which was accepted in the co-contribution model that we have. They made recommendations about the three levels. In terms of how that translated to the actual, specific five-to-50 per cent and 17.5-to-80 per cent, that was work that the department did. The department worked up a range of scenarios for government consideration, and then it was a decision of government as to how that was turned into the rates that we have now.

Senator ALLMAN-PAYNE: Was the government given a range of options for percentages?

Ms Trainor: I couldn't talk to the details of what options those would be, but over the period we considered, we modelled what those would look like and what impacts those would have on people and on providers, as well as the physical impact.

Senator ALLMAN-PAYNE: Was modelling done to determine the impact on full pensioners, part pensioners and self funded retirees as cohorts?

Ms Trainor: We have prepared a range of case studies that are now publicly available, as well as considering what that looked like at those different levels for people based on what we expect average package consumption to look like in terms of how a person uses the clinical, independent and everyday living at different stages of their time in the Support at Home program.

Senator ALLMAN-PAYNE: Are you saying that the case studies that've been made public formed part of the modelling that was given to the minister to help make the decision?

Ms Trainor: It's probably more accurate to say that those case studies are based off the model, and that model is what's built into the Services Australia system for completing means assessments for people ongoing, as well.

Senator ALLMAN-PAYNE: Okay. Has the department done any modelling on what will happen to hourly rates now that providers can no longer charge management or administration fees? And what will be the likely increase in hourly rates?

Mr Pugh: That'll be one of my colleagues.

Ms Snow: Apologies, Senator, I caught only the second half of the question.

Senator ALLMAN-PAYNE: The question was: has the department done any modelling on what is going to happen or is likely to happen to hourly rates now that providers can no longer charge management or administration fees? And if you have, have you come to a view of what will be the likely increase in hourly rates?

Ms Snow: We've obviously done some internal modelling to think about what the settings could do to the market. That has been informed by a survey we did earlier this year where we asked providers to provide advice about indicative prices. As the committee would be aware, it's up to providers to set their prices as they do today under the Home Care Packages Program, and we see a variance of about four per cent in prices across that program today. So, some settings are changing, but it is similar in terms of the price setting that does occur under the current program.

Senator ALLMAN-PAYNE: When you say four per cent, do you mean a variance in four per cent between the highest increase a provider has said they might make versus the lowest increase or that you think they will increase by four per cent?

Ms Snow: The four per cent was what happens today under the Home Care Packages Program—we see, on average, a variance of four per cent when people are setting their prices under the current program.

Senator ALLMAN-PAYNE: My question is: when you say four per cent and you say variance, is it a variance of four per cent between the lowest and the highest fee charged?

Ms Snow: Yes.

Senator ALLMAN-PAYNE: Or a four per cent increase?

Ms Snow: Four per cent between the lowest and the highest.

Senator ALLMAN-PAYNE: Based on the survey of providers, have you got information on what the likely increase will be?

Ms Snow: We have done some internal planning, but we are reluctant to say that that is what will happen, because providers are still working on service agreements with participants.

Senator ALLMAN-PAYNE: Has the government considered the impact that it will have on older people in having to pay those higher fees?

Ms Snow: Of course. I might invite Ms Trainor to provide some information about the hardship arrangements that will be in place under the Support at Home program.

Senator ALLMAN-PAYNE: I will leave it there. I'll come back to hardship, but I need to share the call.

CHAIR: Senator Ruston.

Senator RUSTON: I asked you earlier this morning in relation to the person on the DSOA and I'm just wondering if I could ask some questions here? I have permission, but I won't use his name. If there is a point at which you wish for it, I'm more than happy to show you the permission.

Mr Comley: As discussed, we can't work on the basis that we can talk about an actual individual unless we had consent. Even then, we'd be concerned about discussing an individual in a public forum. If you're effectively putting forward a cameo or a case study and asking us to respond to how that would be dealt with, then that's fine, but we obviously can't talk about an individual.

Senator RUSTON: I'm hoping that maybe, after I give you the story, you might feel that he's been hard done by, and you might action it. After you hear what I've got to say, you'll see he has been through hell. I'm now going to appeal to you, Mr Comley, to take action to sort this out for him. The person I'm talking about became an incomplete quadriplegic in 2010. He was under the age of 65 when this occurred to him. At the time the NDIS came into place, he had aged out of being able to go onto the NDIS. He remained on the Disability Support for Older Australians program, which we are now talking about.

Last year, he applied for respite with the department through the DSOA and over three months he was told that, because of some problem with the computer system error, he wasn't able to obtain respite through this and that he needed to obtain respite through ACAT. The reason he needed the respite at the time was that his wife had been diagnosed with cancer, was undergoing in-hospital cancer treatment and was unable to continue with his care because she was his carer. The gentleman went to get the ACAT assessment for respite. However, he was unaware at the time that, if you get an ACAT assessment in totality for a home-care package, your DSOA package is capped. He was not seeking that. He was merely seeking temporary respite while his wife was undergoing her in-hospital treatment. However, for some reason, and without his consent, the ACAT assessor assessed and made application to the department for a home-care package. He was then informed that his DSOA was now capped and there was nothing he could do about it.

He made applications through a number of means, including seeking a judgement in relation to this with the Aged Care Quality and Safety Commissioner. He initially went to the NDIS complaints commission. They told him the issue didn't fall within their jurisdiction. He then made a complaint to the Commonwealth Ombudsman, who completed an investigation. The Ombudsman recommended that the capping be revoked, but the department refused again. A second attempt was made to this NDIS complaints commission, which they eventually accepted was their responsibility, and so it was advised that the complaint was lodged with the ACAT tribunal. To our understanding, there's no such thing as the ACAT tribunal. As we sit here today, the person concerned has made representations to ministers—Minister Shorten, Minister Butler and Minister Cook, in South Australia. These were all sent back to you as the department.

Today, as we're sitting here, the person concerned is becoming a complete quadriplegic because of the deterioration of his condition. He has been assessed by the people who were providing his care as requiring significantly increased care because of the deterioration of his condition. It appears as if nobody is arguing with the fact that he did not consent to having an ACAT assessment for a full home-care package, but, for some reason, the department and everybody else that he's contacted has refused to overturn that decision, which would enable him to continue to get the care that he requires and would otherwise have been receiving were it not for the failure of the department, in the first instance, by telling him that he couldn't get an assessment for respite under DSOA—which we believe he could have—and by making him go to an ACAT assessment, which was wrongly applied and wrongly administered. As we sit here today, the gentleman's condition has significantly deteriorated, and, quite frankly, it is totally unacceptable that he has not had any remedy for what, apparently, appear to be failures not of his own making. I won't use his name today. But, I plead with you, could somebody actually please take this seriously?

Ms S Stewart: Thank you very much for sharing that. I'm genuinely sorry to hear of his deterioration. I would be very willing to meet up with you and him privately to discuss his matter. I give that invitation with sincerity and would be interested in following that up with you.

Senator RUSTON: Just an immediate internal review. I'll provide you with the gentleman's details off-camera, and can we get this resolved as quickly as possible because the gentleman doesn't have a lot of time. Can I go to the packages? Today you provided me with information on questions that I asked you, and you provided me with information about how many people are on the national priority system waitlist. Can I confirm that since you last gave me information, which was at the end of July 2025, we have seen an increase of nearly 13,000 additional people who have gone on to the national priority system in that time?

Ms S Stewart: Yes, that's correct. I wonder if Ms Snow is here. I think it's important to express the delineation between the NPS and the waitlist. Are you able to do that?

Ms Snow: I'm very happy to do that.

Senator RUSTON: The NPS and what?

Ms Snow: So, obviously the national priority system is the queue, as we've discussed before, but people may be seeking services through other programs whilst they are sitting there.

Senator RUSTON: Did you say, 'sneaking services'?

Ms Snow: Seeking.

Senator RUSTON: I was hoping you didn't say that. They're on the national priority system and you've provided me with this—in March to September, we've gone from 87,000 to 122,000. We seem to have a fairly static amount of people, around 120,000, that are still waiting to get assessment. So, how many packages were released from 1 July to 30 September 2025?

Mr Pugh: Through to 30 September, we had 3,665.

Senator RUSTON: Of the 20,000 packages that were legislated?

Mr Pugh: Yes.

Senator RUSTON: Could you explain to me—the Aged Care (Accommodation Payment Security) Levy Amendment Bill, that was passed on the same day as the ACOLA bill, received royal assent on 5 September, whereas the Aged Care and Other Legislation Amendment Bill didn't receive royal assent until 19 September, some 15 days after the other bill. Why didn't they occur on the same day?

Mr Day: The process of royal assent is something that's managed by the Office of Parliamentary Counsel. I don't have a great deal of visibility about what happened between those two events other than the levy bill got assent on 5 September and the other legislation bill was then passed on the fifth. Sorry, I might have my dates slightly mixed up.

Senator RUSTON: 19 September. 15 days later.

Mr Day: The two pieces of legislation that were passed on that Thursday of the last sitting week both received assent on the same day on the 19th. There wasn't anything different about the treatment of the ACOLA bill, but that was the time that assent process took.

Senator RUSTON: You said there wasn't any difference. The accommodation payment security levy bill received royal assent on the fifth and the ACOLA bill received royal assent on 19 September. I'm keen to understand why.

Mr Day: I think what I was trying to articulate for you is that the levy bill passed both houses a day earlier than ACOLA, and it then got assent the following day. The ACOLA Bill and another bill, the Treasury laws amendment bill that was passed on the Thursday of that sitting week, both didn't get assent until the 19th.

Senator RUSTON: So there was no executive council in the intervening week?

Mr Day: As I say, the process is managed by the Office of Parliamentary Counsel. There wasn't an intervention one way or the other from the department.

Senator Green: I'm not sure the department can answer that question for you, because it's not managed by them.

Senator RUSTON: Well, maybe you can answer.

Mr Comley: We're happy to take it on notice, Senator, but, as you know, with your experience, executive council doesn't meet every day, so we will take on notice—

Senator RUSTON: It meets every week.

Mr Comley: where it got to the first available executive council—

Senator RUSTON: It would be an unusual thing for executive council not to meet every week.

Mr Comley: Well, let's take that on notice. My experience is that executive council meets infrequently.

Senator RUSTON: One of the amendments—and I think it was my amendment or Senator Allman-Payne's amendment—actually required the packages to be immediately released on royal assent. It think it was Mr Pugh who just told me that, of the 20,000 packages, only 3,665 had been released on 30 September, which is some 11 days after it received royal assent. So we've still got 16½ thousand packages that hadn't been released by the end of the month. It's really quite interesting that one bill gets royal assent and the other bill doesn't get it until two weeks later despite the fact that that provision was put into the bill—and that the government voted against that provision being in the bill.

Ms Laffan: Senator, perhaps I can add some explanation for you. The levy bill didn't have any amendments made, but the ACOLA Bill did, and, because of that, it needed to be approved by both the President of the Senate and the Speaker of the House before transmission to the Governor-General. The Speaker's approval, I think, took a little bit longer than is usual, and OPC, as Mr Day suggested, was handling that process.

Senator RUSTON: Okay. Given the importance of this bill, I would have thought that every effort would have been made to have got the thing through, but I also would suggest that every effort might have been made for the 20,000 packages to have been released by now. The fact is, as we sit here today, you've just advised so few by 30 September, and you've still not released half of them to date. You, obviously, say you'll get them done by the end of October, but you were required to release them at royal assent, which you haven't done. Could I ask you, then, how you decide where to—

Mr Pugh: Can I just clarify that, Senator. The intention behind those 20,000 was to have them released between the date of royal assent and the commencement of the Support at Home program. We took the approach of literally dividing 20,000 by six, and you get an uneven number with a decimal place and a few bits after it. We just literally rounded to the closest whole figure, and that informed the rollout cadence. We also have some system limitations, where you can only release 3,000 packages per day. And don't forget that we are also releasing—I promise that is a system limitation. We are also releasing the additional 2,000-plus recycled packages per week as well. At midnight on a Tuesday and at midnight on a Wednesday, these packages go out.

Senator RUSTON: But your maths would tell you that—3,000 a day—you could have had them all out in a couple of weeks, and you haven't. Can I ask you, Minister, to find out why there was an unusual delay with the Speaker in terms of his providing the necessary sign-off on this.

Senator Green: I don't think it's relevant to this committee. I think it's a question around exco, but we'll find an answer for you.

Senator RUSTON: It is relevant to this committee because of the impact on its delay.

Senator Green: No, I mean who might hold the answer. That could be—

Senator RUSTON: Sure, but if you could find out—take it on notice.

Senator Green: Sure.

Senator RUSTON: Thank you. How do you decide where a package is released?

Mr Pugh: We have the national prioritisation system. Where the package is released—we don't do that on a geographical basis. The package is allocated to the next person in the queue, and that is based on the length of time they've been waiting and their assessment outcomes—their priorities. We talk about higher priority people getting access to their package within one month, so those people will get something that's been assessed at a lower level, and it's literally the next person who falls due for their package who gets it. We do not discriminate based on where you are across the country.

Senator RUSTON: No, no. I wasn't suggesting that you were discriminating. I'm just keen to understand—you've got 120-odd thousand people that are lined up on a list here. I understand priority 1, but there are not very many of them in comparison to the number of people that are on the medium list. So how do you make that decision? Are people prioritised within the medium range in terms of the length of time and level of need?

Mr Pugh: It's literally when you get to the top of the queue, based on your priority order.

Senator RUSTON: Okay.

Mr Pugh: You have waited your set amount of time; you're at the top of the queue; you get your package.

Senator RUSTON: Are people on lower packages than assessed included in these figures?

Mr Pugh: In the numbers that we gave you in advance?

Senator RUSTON: Yes.

Mr Pugh: They are, I think, yes.

Senator RUSTON: There are 121,909 people who are waiting for a package that they've been assessed as needing. Does that include the 16,000 people who are on a package that is actually lower than they've been assessed as needing?

Mr Pugh: It does, yes.

Senator RUSTON: So they're included in those numbers? Okay. How many people on the MPS are in hospital?

Mr Pugh: I'll have to take that one on notice. I can get back to you in this session, if I possibly can. I don't have that in front of me, sorry.

Senator RUSTON: Minister, do you know how many people on the MPS have passed away between 1 July this year and 30 September?

Senator Green: Thank you for the question. Obviously, it's really heartbreaking to hear that people pass away while waiting for care. That's exactly why we're trying to deliver these changes. I've got a figure for you of people who've passed away while on the national priority system in this financial year. I can confirm for you that, sadly, 4,812 Australians passed away while on the national priority system in 2024-25.

Senator RUSTON: Sorry, you said that, in 2024-25, it was four thousand—

Senator Green: Yes. Is that the—

Senator RUSTON: No, I was asking about how many people had passed away between 1 July this year and 30 September this year.

Senator Green: I'm sorry. I don't have that breakdown, but I do have the full financial year for you—the previous financial year—and, of course, it's awful to hear that that has happened. We certainly want to bring about these changes to try to prevent that as much as possible.

Senator RUSTON: I'm keen to understand if there's been any budgetary implication—

Senator Green: Any—sorry—what?

Senator RUSTON: This is to the department. I'm keen to understand if there has been any budgetary implication, when the budgets for funding of home care or Support at Home—care that is delivered in the home—would have been set on the basis that you were going to start the Support at Home program on 1 July 2025. We have seen, basically, the withholding of all new packages, with the exception of the few that you've just mentioned, Mr Pugh, for a period between 1 July and 30 September. So that means that these packages haven't been funded for anyone, because the care has not been provided, because the packages haven't been released. I'm

keen to understand if there are any budgetary implications from the withholding of this care, basically, for three months.

Ms S Stewart: I note that you used the word 'withholding' care. In terms of the 83,000 packages, they have been budgeted, and any changes to the sequencing of those will be addressed in the forward budget processes that will be announced by the government.

Senator RUSTON: So, as we sit here today, Ms Stewart—

Ms S Stewart: I'm sorry but I can't hear you. I'm not sure if it's me. I'm sorry, Senator Ruston.

Senator RUSTON: Sorry. I can yell. I just try—

Ms S Stewart: It might be me, I'm sorry.

Senator RUSTON: I just don't want you to think I'm yelling at you.

Ms S Stewart: No, no. It's okay.

Senator RUSTON: I'm interested to understand, Ms Stewart, on the basis of what you've just said, what the trajectory of release of packages was for 2025-26 that was anticipated when you were believing that you were moving to Support at Home on 1 July? At the time, you said there were going to be 83,000 packages. We've subsequently had to legislate for that to happen. But, when you were intending to start this program on 1 July, you must have had a rollout plan as to when these packages were going to be released.

Ms S Stewart: Mr Pugh can answer that.

Mr Pugh: I'm happy to take that question. I don't have the numbers, specifically, in front of me, but it might be helpful to revisit the way that the system governor and the legislative basis provide for the allocation of packages. The Aged Care Act 2024 prescribes the method by which those places will be allocated. That doesn't require the minister to prescribe how many places—just the method of how that number of places will be allocated. So—

Senator RUSTON: Excuse me, Mr Pugh. In order to be able to have put a funding allocation against 2025-26, you must have known the profiling of those packages; otherwise, you couldn't have come up with a number. Clearly, you must have profiled those packages, and I'm keen to understand what the profile was. I get the act doesn't say that you have to, but for budgetary purposes you must have done it.

Mr Pugh: Yes, but that modelling would be subject to cabinet deliberations, and I don't think I'm at liberty to advise of that, either in this forum or on notice, sorry.

Senator RUSTON: When will we see the savings that have occurred because no new packages have been released in this three-month period?

Mr Pugh: The Treasurer came out as part of the deferral announcement and announced that there were no savings attached to the deferral period. In fact, there was a cost attached to it. That's been out in the public domain.

Senator RUSTON: Could you explain to me how that cost would have occurred? What was the cost of the delay?

Mr Pugh: The Treasurer has announced that the cost of the delay was around the $900 million mark, and there were a range of factors that were incorporated into that. The two main drivers would be the loss of co-contributions under the Support at Home program, and the cost of maintaining people in a home-care package, which is around $5,000 more expensive than an equivalent Support at Home package. There are other cost drivers. These will all published in the MYEFO context.

Senator RUSTON: Can you unpack that for me? You said that, for somebody who's on a home-care package, it would be $5,000 less when they got a Support at Home package?

Mr Pugh: At an equivalent level.

Senator RUSTON: But I thought the majority of people were grandfathered.

Ms Snow: I think we're talking about the structure of moving from four home-care packages to eight. By having more granular funding tiers within the new program—

Senator RUSTON: But you're not going to take somebody who's been assessed as needing this level of care and then tell them they're going to have $5,000 less.

Ms Snow: You're right. Grandfathered people retain their current—

Senator RUSTON: So I'll contest, Mr Pugh, that your argument around the $5,000 is irrelevant. It doesn't make any sense.

Mr Pugh: The allocation of funding under Support at Home is more efficient, and we have seen some inefficiencies in the Home Care Packages Program, and that is shown by the public data on utilisation rates and the like.

Senator RUSTON: And yet, in your funding envelope, in terms of the profiling of the funding with the changes to the Aged Care Act, you actually run at a loss for the first few years. So you're saying that, by not bringing it in, it's cost you, and yet, by bringing it in, it was going to cost you. That doesn't make any sense either.

Senator Green: The officials have said, and I think this is a matter of public record, that there weren't any savings in terms of deferring, and actually the costs will be—

Senator RUSTON: I know. That's exactly what they said, and my question is about that.

Senator Green: And I'm clearing that up for you. What the costs were will be in MYEFO.

CHAIR: Senator Ruston, I'm seeking some clarity on how much more time you need. I've tried to be fair in allocating the call. Can I temporarily allocate the call to Senator Ananda-Rajah before we head off to dinner?

Senator RUSTON: I would like some more time.

CHAIR: We'd all like more time.

Senator RUSTON: But I'm not getting a lot of it. I'm happy to change topics, if that's what you'd like me to do.

CHAIR: How much time would you need?

Senator RUSTON: With seven minutes to go, I'm quite happy. But we're coming back after dinner.

CHAIR: If you can hold off until after dinner, we'd be grateful. That would help—very much so. I'll allocate the call to Senator Ananda-Rajah.

Senator ANANDA-RAJAH: I'm interested in First Nations and our approach to aged care in this community. It's a priority for the government. I'm just concerned we're not going to be discussing it in this session, and I think it's important to raise it in this session earlier rather than later.

Ms S Stewart: I might start off and then ask Ms Harper and Ms Tatipata to go into some details. I think the first thing to focus on is the act. For the first time, the act is going to be older-person-centric and particularly for Aboriginal and Torres Strait Islander people in terms of culture, and trauma informed, which I think is very important. I think there are other key aspects in terms of the whole system, with the piloting of an assessment pathway for Aboriginal and Torres Strait Islander older people—our Elders. There are also expectations of the providers in terms of quality and standards.

The other thing I would say before I hand on is that, as an Aboriginal woman, the voice of our elders is very important in terms of listening to them through the Council of Elders as well as in evaluation, and ensuring that Aboriginal and Torres Strait Islander people access to the levels that they represent in the population. I'll hand over to Ms Harper to go into some more detail.

Senator ANANDA-RAJAH: Could you also talk a little bit about culturally appropriate care and how it will be provided through this system? I think that's really important.

Ms Harper: I will hand to Ms Tatipata very shortly to take you through in a little more detail—as pointed out and reflected on, the focus on putting the older person at the centre of everything we do is really key, and obviously no more so than in the First Nations aged-care space. The importance of culturally appropriate care and ensuring that we equip all providers—whether or not we are drawing and learning from our Aboriginal community controlled organisations in this process or looking to uplift and upskill all providers across Australia who are providing care to older First Nations Australians is a real focus of government. At this stage there are a range of initiatives that we have in place—

Senator ANANDA-RAJAH: Please describe some of them. That would be great.

Ms Tatipata: Some of the initiatives that are existing as well as there's been further investment in are around the Elder Care Support program—which is work that we've undertaken with NACCHO, partnering with our Aboriginal community controlled organisations as well. The focus of this workforce is to work directly with the older Aboriginal and Torres Strait Islander people as well as elders to ready them for the aged-care system but also support them through their aged-care service experience.

We also have the Indigenous Employment Initiative—which my colleague mentioned earlier—around the rural and remote, which is really focused on increasing Aboriginal and Torres Strait Islander people working in aged care through entry-level employment and non-clinical-type support. We also have our National Aboriginal and

Torres Strait Islander Flexible Aged Care Program, which is also really focused on working in a culturally safe way with our elders and meeting their changing needs as they navigate the aged-care system.

Senator ANANDA-RAJAH: Has the Indigenous workforce initiative started? Has that pathway kicked off?

Ms Tatipata: Yes. That's been a program that's been—

Senator ANANDA-RAJAH: Do you know how many people are going through the training program, or could you take it on notice?

Ms Tatipata: In terms of the Indigenous Employment Initiative?

Senator ANANDA-RAJAH: Yes.

Ms Tatipata: We have currently employed 1,016 Aboriginal and Torres Strait Islander people.

Senator ANANDA-RAJAH: Fantastic. Are you seeing a lot of interest in the program.

Ms Tatipata: Yes.

Senator ANANDA-RAJAH: How do people find out about it if they're interested?

Ms Tatipata: That's a grant opportunity that—we work with our aged-care service providers and identify where need is, particularly in remote areas.

Senator ANANDA-RAJAH: With respect to the quality and standards you mentioned, Deputy Secretary, perhaps you could elaborate. Are they any different to the broader quality and standards that we're implementing throughout the whole sector? There's been a huge change obviously. Are there any nuances to First Nations communities?

Ms Leonard: The strengthened quality standards—which will take effect from 1 November this year—include requirements to deliver, specifically, culturally safe and appropriate care for Aboriginal and Torres Strait Islander people. There are a number of the standards which have quite specific requirements—in particular standard 1, which deals with person-centred care, requires providers to demonstrate that they understand individuals, including their identity, their background, their culture and their diversity. Also of relevance is standard 3, relating to the delivery of funded aged-care services, that providers must demonstrate that aged-care services are delivered in a way that is culturally safe and culturally appropriate for individuals. Those changes to the strengthened standards represent a significant uplift and focus on culturally appropriate care.

Senator ANANDA-RAJAH: My last question is—and you've only got a minute—can you describe to us the engagement you had with stakeholders and the government in formulating this approach?

Ms Leonard: To the strengthened aged-care quality standards?

Senator ANANDA-RAJAH: Yes.

Ms Leonard: There was a review of the standards following the aged-care royal commission, which involved a significant number of consultations with a variety of stakeholders—including First Nations people, aged-care providers, older Australians, families and representatives. It really identified the need for specific mention of culturally safe and appropriate care.

CHAIR: Thank you very much. The committee will suspend now for the dinner break.

Proceedings suspended from 18:15 to 19:00

CHAIR: We are quorate. We are still in outcome 3 of ageing and aged care. I will hand the call to Senator Ruston.

Mr Pugh: Senator Ruston, before the break you asked how many packages had been released by 30 September 2025. I mistakenly said 3,665. That was a simple mental maths error. The number should have been 6,665 and, of course, the 10,001 as of today's date.

Senator RUSTON: You issued a press release on Monday saying that it was 6,600 as of Monday. So there had been no home-care packages released since 1 October until this Monday.

Mr Pugh: No, not quite. Before the break, you asked how many new home-care packages had been released as at 30 September.

Senator RUSTON: Yes.

Mr Pugh: I mistakenly said 3,665. The number should have been, as at 30 September, 6,665. I just didn't add two things together.

Senator RUSTON: But the minister issued a press release on 6 October saying that number. So were there no packages released between—

Mr Pugh: No, there were. So, at midnight tonight and midnight last night, that takes us to 10,001 this week.

Senator RUSTON: No, on Monday or Tuesday this week—the 6th—the minister issued a press release saying that, as of 6 October, there were 6,636 packages that had been released. You're telling me that's the number from 30 September. I'm just asking you: were no packages released in the six intervening days?

Mr Pugh: They were. They were released last night and tonight, so on Tuesday night and Wednesday night.

Senator RUSTON: No. From 30 September, the figure you gave me—until 6 October, when the minister issued a release to say 'as of that date'—is the same number that you just quoted to me. I'm asking: were there no packages released in the six days between 30 September and 6 October?

Mr Pugh: That is correct. I am clarifying that those packages for this week were released on the subsequent days, so on 8 October and 9 October.

Senator RUSTON: Fine. I made some calls in the break. I rang a number of really big aged-care providers who provide home care. Not one of them has said that they have a new person on their books with a home-care package. When you say you've released these home-care packages, what does that actually mean?

Mr Pugh: It means that the home-care package has been released to the participant or to the client. It is then up to them to then go and find a provider and actually proceed with that service.

Senator RUSTON: I made quite a few phone calls. Not one provider has told us they have received a call from somebody with a new package. It's very interesting that they've been released, but they don't seem to have actually made their way into the market.

I'll go back to the questioning we had before dinner about the financial aspects of this. You said that, at the time of the announcement of the four-month delay of the start of Support at Home—the act—from 1 July to 1 November, the Treasurer said that there was a cost in that period of $900 million or thereabouts. Over a 12-month period, that equates to $2.7 billion that would potentially be a saving from the existing program, had the Support at Home package been in place on 1 July. You must have provided the Treasurer with a breakdown of how those additional costs would be incurred because of the four-month delay. Do you have that breakdown or did you advise the Treasury of that breakdown of those costs?

Mr Pugh: I don't think that's quite accurate because in the MYEFO context at the back end of last year—2024-25—the Support at Home program was announced as having a $4.2 billion cost. There was the cost of deferral, and the breakdown of that cost will be provided in further detail as part of this year's MYEFO context.

Senator RUSTON: This is the piece that I'm really struggling to understand. The implementation of Support at Home had a $4.2 billion cost associated with it—I think it was over the forwards. You have advised us that there was a $900 million cost not to implement it. It doesn't make any sense that it's costing you not to implement it, and yet it was going to cost you to implement it. It seems quite contradictory. Can you provide me with some more information about how it can cost you to implement and then cost you not to implement it?

Mr Pugh: I believe I gave evidence around some of the primary cost drivers. I will have to take the rest of those on notice, and, obviously, the finer details will come out in this year's MYEFO context.

Senator RUSTON: Sure. Over the last three years, as a period, how many people were approved for home-care packages each quarter? Is that information available?

Mr Pugh: We can get that for you on notice, unless we've got that as part of our pack.

Senator RUSTON: Even if you can tell us how many people were approved for a home-care package in each year over the last three years. It gives us a bit of an idea of the new packages versus the existing packages that are re-allocated.

Mr Pugh: I can give you the last five-year series actually. The number of allocated home-care packages to 30 June—

Senator RUSTON: Allocated or approved?

Mr Pugh: Allocated.

Senator RUSTON: No, I want the number that are approved.

Mr Pugh: The approval numbers would be slightly higher. I'll just have to double-check. Maybe I'll take that one on notice and get back to you as part of this session.

Senator RUSTON: That would be great. If you could do that, that would be super. Just quickly, in regard to 1 November, is the department absolutely convinced that you will be able to be fully operational in relation to the rollout of the act on 1 November?

Ms S Stewart: I'm the senior responsible officer for the project. I can confirm that the reforms will be delivered on 1 November. I will say, though, that, as I provided evidence before, this is staged digital implementation. This reform happens over a number of releases and a period of time. The main one, of course, is the start of the act. That is happening on 1 November, with system release on that day too.

Senator RUSTON: Will Support at Home go live on 1 November?

Ms S Stewart: Yes, everything exists from 1 November.

Senator RUSTON: Do you expect providers to have signed all of their new agreements by that date with people who were previously receiving home-care packages that are moving onto Support at Home?

Ms S Stewart: I do not expect that everybody would have those agreements signed. One of the things is that we're moving from a very big system to another big system with a lot of change. I acknowledge that the commissioner, Liz Hefren-Webb, is here. One of the things is giving providers and older people time to enter into those services agreements, ensuring continuity of services. I would say that the department has worked with providers and older people advocates in getting older people ready. A key milestone happened on 1 October, in terms of people being able to go and understand what their contribution is. Of course, before that, they were able to go onto the website and get an estimation of any contribution.

Senator RUSTON: That's a great commitment, and we'll be looking forward to seeing that. This is a bit of a random question. I noted that, in the National Housing Accord, it actually says, 'A dwelling is a structure which is intended to have people live in it and which is habitable on census night. Some examples of dwellings are houses, motels, flats, caravans, prisons, tents, humpies and houseboats,' but not residential aged-care facilities. In the process of the development of the National Housing Accord, were you ever asked, as the department of aged care, whether you believe that residential aged care should be considered as part of the accord?

Ms S Stewart: I'll have to take that question on notice.

Senator RUSTON: That's quite interesting. Is the Inspector-General here? Good evening, Ms Siegel-Brown. In a recent media release—I think it was on 4 September—you expressed concern saying:

… the way in which co-payments under the Support at Home program have been implemented risks leading those most in need to delaying or declining essential supports, or even being pushed into residential care.

Can you unpack the basis of that concern?

Ms Siegel-Brown: First of all, it's really important to say that I completely understand that the government is dealing with a finite bucket of money and with exponentially growing demand. It is an unenviable task. I also understand that the model of co-payments was introduced in the first place specifically to widen the bucket of money available to older people to ensure that more older people could access aged care. I endorse that approach.

The point I was raising in my report to which that media release related—let's remember, it was the report of the government's progress on the implementation of the royal commission's recommendations—was that we have seen the introduction of a very noble Aged Care Act that will make a huge difference to the lives of older people but my concern lay with the implementation. In particular, I was worried about unintended consequences. My concern is with respect to the implementation or the structure of co-payments and in particular in relation to full pensioners and part-pensioners and the contributions they may need to make.

The specific sentence that you drew upon there related to a concern where, for example, personal care attracts a contribution from full pensioners or part-pensioners for things like showers—things that we consider part of our basic dignity and human rights—when you accumulate that over a period of seven days and you're still trying to make your full pension of approximately $600 go further, these kinds of costs may become unaffordable. That has a consequence to a person's dignity and human rights. We have really impressive vision within this act for high-quality care and a statement of rights about a person's dignity, agency and connection to their community and to their home. I was worried that that would be compromised.

Equally, I do understand the government's challenge around the funding bucket. I was concerned that I haven't yet seen any modelling of it. There seems to be potentially a gap with the economic modelling that might demonstrate whether paying that small payment—whether they are part-pensioners or full pensioners—might actually offset a person's premature entry into residential aged care or, potentially, hospital because without some of the basics of everyday living, even cleaning can become a clinical need that people may become desperate for residential aged care as a result. That is what I intended by that statement.

Senator RUSTON: To that end, has the department done any modelling on the likely behavioural changes, the extent or the likelihood of what Ms Siegel-Brown has just highlighted as being a disincentive in terms of take

up, which may ultimately result in an earlier entry into residential care? Has the department done any modelling of the likelihood of that happening?

Ms S Stewart: I want to start off by just making some broader comments. The whole intention of these reforms is around choice, dignity and quality and putting older people at the heart of it. They are the true North Star of that. There are a number of safeguards in terms of ensuring that. One of the key ones is the no-worse-off principle. I think that's very important in terms of people who are entering that system at a certain date. The other safeguard is ensuring that only those who can pay will be paying. The third aspect of that is that, where there is hardship, those processes have been streamlined to be more efficient and more effective. I just wanted to give that in terms of the broader context and then hand over to Ms Trainor in terms of the specifics around the modelling.

Ms Trainor: In terms of modelling around what behaviours we might see, I'm not aware of modelling. Mr Pugh may know something of modelling that would suggest a change in behaviour. We have some expectations of what people in different classes would use as a service mix as a baseline. On those, we wouldn't expect there to be a change for people, but, as Ms Stewart has noted, we do have the hardship arrangements, and Services Australia have recently streamlined that process to reduce the number of points of evidence a person needs to be approved for hardship from 18 points to four points, so—

Senator RUSTON: Sorry, Ms Trainor. I was just keen to understand—I'm not quite sure from your answer whether you'd done modelling and it hadn't found that it's likely that there'll be behavioural changes or there has been no modelling and the department just thinks there won't be any behavioural change.

Ms Trainor: We've done modelling about expected use across the categories. What I don't think we have is any modelling about whether that represents a behavioural change from what people use their home-care packages for.

Senator RUSTON: You've modelled the uptake, and surely that's modelled on a baseline of what is the existing situation as to what might change into the future. Are you able to provide to us some information around what you think is likely to change?

Mr Pugh: I'd have to take that on notice. I'm not aware of any modelling. I support what Ms Trainor's saying.

Senator RUSTON: Back to you again, Ms Siegel-Brown. Are you concerned or have you expressed any concern about the government's current approach of largely not releasing home-care packages for nearly three months and the fact that, over the last two years, we've seen an explosion in the wait list from—I think it was 28,000 just over two years ago. It's now 122,000, and the wait times have gone from between one and three months up to—I think, today, they're in excess of 10 months on average from the information and data that's been provided to us. Are you concerned about the impact that this has had on older Australians and their care needs and the impact on them of not getting the care that they've been assessed as needing?

Ms Siegel-Brown: You'd be aware from your time on the aged-care services inquiry that my office made recommendations that the government front load the release of packages. We still consider that really important. We very much welcome the government's decision to release the 83,000 packages and note that the release is in tranches. I'm really happy to see that. I think that doing that will mitigate some of the problems that I raised at that inquiry. I suspect that your question also relates to wait list times. In my 2025 report into the government's implementation of the royal commission recommendations, I did make comment about concerns that the 3-month wait time may be unachievable. At that point, we thought that the 83,000 packages would potentially be released at that time.

Senator RUSTON: Can I just unpack that. You're saying that, even with the release of 83,000 packages, you didn't believe that the wait time would be reduced to three months?

Ms Siegel-Brown: We hadn't seen any evidence that it would be. I do want to acknowledge that, in the earlier part of the year, we were seeing wait times go down. There was some really positive movement there, so perhaps it didn't surprise me that the wait times did increase. I also did say in the report that I felt that three months could be a prejudicial timeframe for waiting, but I also acknowledge again that there is a finite budget that we're working against. For me, the key point here is how we expend that budget. As you can see from both the representations I made at the aged-care services inquiry and my 2025 progress report, I do believe that that upstream investment in home care is going to be key to meeting the government's policy objectives around ageing in place and key to delivering on what I truly consider to be a landmark piece of legislation. As a lawyer with 20 years in legislation, I've never, ever seen the kinds of things codified that are codified in this act, so I'm worried that extended wait times might prejudice the policy objective.

Senator RUSTON: Are you concerned at all about the flow-on consequences—for example, people being in hospital and people being in residential care prematurely because they weren't able to get access to the care that they needed when they needed it?

Ms Siegel-Brown: That was certainly the concern or fear that I raised at the aged-care services inquiry when I wasn't clear that the home-care packages were going to be released, as they are now. But I can see from the timeframes that the government has set for the release of those packages that a number of my concerns will definitely be mitigated.

Senator RUSTON: Okay. In your opinion as the Inspector-General, or do you have a view—in relation to the level of confidence that you have that the government will be ready to implement the act on 1 November?

Ms Siegel-Brown: It's really important to state up-front that I welcomed the government's delay of the act, and I do believe that it has increased the readiness of both the sector and government to hit the go button on 1 November. I don't think anyone's wasted time; I think that that time has been used really wisely.

Senator RUSTON: I'm just keen to understand, if you could perhaps answer this question. It's about trying to understand what your expert opinion is, because that's what your job is—

Ms Siegel-Brown: And forgive me: I'm a painter, not a pointer, so that's a problem I have. But I wanted to make clear that I do believe that the delay has increased the readiness of the sector and of government. But, even if we say, 'We weren't expecting everybody to be 100 per cent compliant and 100 per cent ready on 1 November,' I think there are still some concerns I have about readiness. I'll give you an example. We're still not clear as to what the pricing of home-care items will be. So there are some more major issues that I still am concerned about. And, as you've heard tonight, it is a huge change, and there are a lot of levers to pull. But, yes, I do hold some concerns.

What I have heard, if you're interested in what the sector's saying to me, about readiness is that they are really keen for this act to begin and they're really keen to work through the issues of implementation. But I will be continually monitoring some of those items where I fear that we weren't quite ready yet.

Senator RUSTON: Thank you.

Senator ALLMAN-PAYNE: I want to pick up on a couple of comments that were made in that last exchange with Senator Ruston, before I go to something else. First of all, Ms Siegel-Brown, you've said twice that the government has a finite bucket, the government has a finite budget. Do you accept that that's simply a decision of government about how much money they're choosing to put into aged care?

Ms Siegel-Brown: I would agree that the money that is in the aged-care bucket is absolutely a decision of government. But I guess what I am saying is that as much as I would dream of a universal system, an on-demand system, I understand the realities of it, and that's what I'm trying to convey.

Senator ALLMAN-PAYNE: I just think that's an important point to make, because the government could choose not to spend money on something else and actually give us a demand-driven system. Ms Stewart, you talked about the 'no worse off' principle. I just want to clarify: that principle applies to people who are currently in the system now, doesn't it? When the new system starts, that doesn't apply to new people coming into the system.

Ms S Stewart: Yes. But could I just ask a question? I don't understand how it works with time, but in terms of some of the timing that Senator Ruston spoke about—wait times, lengths—I want to clarify that, because they are not some of the figures that we have. Do we do that when it's Senator Ruston's call again?

CHAIR: If you have that information, you can do that, yes. I'm happy for you to do that when Senator Ruston has the call. I think we'll wait until the deputy chair is finished. It will only be 20 minutes.

Senator Green: In case the deputy chair has questions that relate to those figures, it might be helpful—

Senator ALLMAN-PAYNE: I don't.

Senator Green: That's okay. If there's information to be corrected, I think we should do it, in the interests of all committee members.

Senator ALLMAN-PAYNE: I'm happy to stop the clock and have it corrected, and then I'll restart.

CHAIR: I can stop the clock.

Senator RUSTON: The information I was quoting was the information that had just been received. So, perhaps you could do it when I have the call, because if you're saying that the figures are wrong, then obviously I'd like the opportunity to say, 'Well, I'm only repeating the figures you gave me this morning.'

CHAIR: I do know that Senator Ruston would like to rebut some of that, which is why I was hesitant to do that. I know her well enough.

Ms S Stewart: Apologies if I've disrupted the proceedings.

CHAIR: I'll restart the clock for you, Deputy Chair.

Senator ALLMAN-PAYNE: Thank you. I actually need to direct some questions to Mr Pugh, please.

Ms Trainor: Senator, do you want to go through the no-worse-off-principle eligibility whilst Mr Pugh comes to the table?

Senator ALLMAN-PAYNE: Yes.

Ms Trainor: So eligibility for the no-worse-off principle for Support at Home is based on whether a person was first approved for a package on or before 12 September last year. For residential aged care, it's whether or not the person has permanently entered aged care on or before 31 October coming. That doesn't include respite; it's specifically permanent care.

Senator ALLMAN-PAYNE: That's great, thank you. It goes to my point that if we have concerns about co-payments, the no-worse-off principle is really only talking about people who are already in the system. It doesn't apply to the people after.

Okay, Mr Pugh, before dinner you told me that there were 300,000 additional Support at Home packages coming over the next decade. However, when we look at the budget papers—I'm looking at an extract from table 2.3.1, 'Budgeted expenses for Outcome 3' on 'Aged Care Services' in the health portfolio budget statement—funding for Support at Home looks pretty stable each year. Now, before the Senate inquiry that we had into aged-care services delivery, the minister was telling everyone that the government was releasing over 2,000 packages each week, but then it turned out that they were recycled packages from when other people leave the system. There was no actual increase in the total supply of packages. What I want to understand is this: those 300,000 packages over the decade, are they actual new packages or are they recycled packages?

Mr Pugh: They're extra packages.

Senator ALLMAN-PAYNE: Okay.

Mr Comley: Mr Pugh can correct me, but I think it is a policy commitment to have an extra 300,000 packages across that period.

Senator ALLMAN-PAYNE: Yes.

Mr Comley: What you're really alluding to is it's not in the budget yet because the government hasn't decided at which point to allocate them, but there is the policy commitment to put the 300,000 packages into the system.

Senator ALLMAN-PAYNE: Yes, and that's the point I'm getting to. The budget papers show that from 2025 there's only a 0.3 per cent increase between now and June 2029. There's a commitment to do 300,000 packages over the next decade, but they haven't been budgeted for. Is that correct?

Mr Comley: It's not unusual, when you have longer term commitments like this, the timing you choose to actually give effect to when they're putting in changes the point they're recognised in the budget.

Senator ALLMAN-PAYNE: Yes, but what that means is there's no guarantee, for example, that we're going to get an extra 30,000 in 2026-27, because that's not showing up in the budget papers.

Unidentified speaker: There's also no guarantee that they will be in government.

Mr Comley: It's a matter for government, but, at the same level, different people look at the budget paper in different ways. Even if you have something in the budget papers, it's always up to a government, whether the current government or a future government, to change their minds about those things. It's the policy commitment the government has made to put the extra 300,000 packages over that period.

Senator ALLMAN-PAYNE: Okay, so there's a policy agreement. Is there an actual plan to release an increase in packages beyond this year, or just a policy commitment?

Mr Pugh: There's an actual plan because the $4.2 billion announcement that was made in the MYEFO context last year would budget for those packages over the forward estimates. To the secretary's point—

Senator ALLMAN-PAYNE: But they're not in the budget. That's what I don't understand.

Mr Pugh: I think they are. They would have to have been if they were announced in MYEFO last year. We can take that on notice and get you some more specifics.

Senator ALLMAN-PAYNE: I think you will, because if we look at the numbers, there's no increase. We don't understand how you can be going up by 30,000 every year—the budget would have to go up concurrently, and it doesn't. That's the point we're trying to understand. The reason we're concerned is we've been told there isn't modelling for demand for Support at Home, there hasn't been the modelling for the impacts of the closure of

CHSP on Support at Home. We're being told the waitlist is going to be brought down to three months by July 2027. We have a promise to release packages, but they don't appear to show up in the budget. If you can give us something on notice that clarifies that, that would be super helpful.

Mr Pugh: More than happy to, Senator.

Senator ALLMAN-PAYNE: Okay. I want to go to hardship provisions. Somebody mentioned those earlier. I'm keen to understand the streamlining of them. My understanding is, at the moment, the form to apply for hardship is 17 pages long and you need to provide three months of expenses—is that right?

Ms Trainor: It's those three months of expenses that have been streamlined under the changes Services Australia have commenced, effective early August. Previously a person was required to provide evidence of their eligibility against having completed a means test, meeting certain gifting rules, being below a realisable assets threshold, and then a whole lot of supporting evidence associated with the expenses they put on the form. Now, with most of those expenses categories, what the person puts on the form is treated as fact rather than them needing to provide total evidence—so it has significantly reduced the evidence burden associated with the form, although the form itself hasn't changed in length.

Senator ALLMAN-PAYNE: It's still 17 pages?

Ms Trainor: Services Australia could tell you the exact number of pages, but the form itself has not become significantly shorter.

Senator ALLMAN-PAYNE: My concern is how people who are struggling do this. I'm in the process right now of assisting my dad in going into aged care, and the amount of paperwork is insane. I don't know how, if he didn't have the assistance of a family member and others, he would get that done. A lot of the people who need hardship provisions are vulnerable, and I'm concerned that we're saying, 'Co-payments are high, but it's okay because there are hardship provisions,' but the process for the hardship provisions is not easy. How does someone do that? It may be a question for the minister. Is that a good system, where we're saying, 'We're going to make it out of reach for some people, but then we're going to have a process that's not easy to navigate'?

Senator Green: I just want to check with the officials whether it's Services Australia that administers that.

Ms S Stewart: Yes.

Senator Green: The reason I'm asking is I think there might be more information we can provide you about the assistance people might be able to receive to fill out that information, in the normal way that someone approaching Services Australia might need to do that, whether it's aged care, home-care packages or any type of assistance from Services Australia—disaster management and things like that. I think it does sit with Services Australia.

Senator ALLMAN-PAYNE: It might sit with Services Australia, but it is a policy of the department. The other thing I want to point out is a lot of people who are highly vulnerable, who are the people who need those hardship provisions, have spent a significant period of their life engaging with Services Australia in ways that are quite traumatising, and we're asking them to go through a lengthy process. I don't understand why you haven't designed a system where, if somebody is poor and can't afford the prices you've set, you would change the way you calculate who is eligible for what price so that they don't have to go through this process.

Senator Green: We're seeking to get that information for you about what—

Senator ALLMAN-PAYNE: But that's not what my question was.

CHAIR: Can we wait until the minister finishes her answer. I'm keen to find a way we can get through this.

Senator Green: I'm trying to answer your question, is what I'm saying. If you want to let the officials respond, they're trying to answer the question for you.

Senator ALLMAN-PAYNE: The point I'm trying to make is it would seem to me to be—

Senator Green: You keep making a point but you don't let the officials answer. If you finish the point you're making, then they can probably provide you with the information you're after.

Senator ALLMAN-PAYNE: The point I'm making is there's been a system of co-payments designed that clearly, based on what we've heard in the service delivery inquiry and what we're hearing from advocates, is going to price some people out of accessing services. That's the evidence we heard in the inquiry. The question I'm asking is: why would you design a system that has this complicated process of having to go through a process to apply for hardship when, if you designed the percentages for the co-payments—maybe this is a question for you, Minister, because this was a decision of the government. Why did the government choose a level of percentages that necessitates an additional step for people experiencing hardship?

Senator Green: People who are experiencing hardship have access to that support. That's what you're asking about, isn't it?

Senator ALLMAN-PAYNE: No, I'm saying you could have set the percentages that they have to pay for co-payments for Support at Home so that, if they don't have any means, they don't pay a co-payment. But instead they've got to apply for hardship. I don't understand why there's a separate process for that.

Senator Green: The system we've funded and designed will deliver that generational reform that is needed in this under-demand system. That's why we're delivering this reform. That's why we're ensuring that people who can do contribute costs. I can let the officials explain to you how they will interact with Services Australia; I think that's what you're after.

Senator ALLMAN-PAYNE: I'm happy for that to be taken on notice. I was after the answer you gave me, as to why the government designed it that way. You've given me as good an answer as I'm going to get on that.

Mr Pugh: I'm happy to provide some additional information in relation to the way people can engage with Services Australia. We've got 81 aged-care specialist officers; they're in primary sites, with an additional 50-plus sites that can be accessed via outreach and dual servicing arrangements. We've got a very good network of face-to-face aged-care service officers out there who can help walk through what those hardship provision arrangements look like. We've also got 132 financial information officers who service over 230 locations. The Services Australia face-to-face delivery to help those folks who are experiencing hardship is real. They are out there.

Senator ALLMAN-PAYNE: I don't dispute that. It would seem to me to be a false economy to have to employ people to do that process when you wouldn't have to do it if you just designed it the other way.

I'm going to move on. I understand that people who were grandfathered in the system before September—thank you for clarifying that. If you need a reassessment and you go up a level of care, are you still grandfathered to the old rules or will you be forced to pay the new co-payments once you go up a level?

Ms Trainor: To be clear, under Support at Home everyone will move to a co-contribution model that's based on a co-contribution as a percentage of the service cost of what you've received. The no-worse-off-principle group will pay lower transitional rates and will remain on those transitional rates for life. Even if their care needs increase and they move to a Support at Home class package, they will remain on those transitional co-contribution rates in that higher level of care.

Senator RUSTON: Are you talking about the existing co-contribution or the new co-contribution?

Ms Trainor: Under Support at Home and the new co-contribution, if a person is re-assessed and moves to a higher-level Support at Home class, if they were eligible for the no-worse-off principle based on that 12 September 2024 date, they remain on those transitional rates even if they change package classes.

Senator ALLMAN-PAYNE: I want to go to the time for aged-care assessments. I'd like to know the current number of people on the waiting list for assessments. The last information we had at the end of July was 121,596. Do you have the number of people waiting for an assessment as of today?

Mr Pugh: The evidence we provided at that service delivery inquiry noted that we were experiencing some initial issues with the Single Assessment System at the outset. We noted that some of those issues were around the time taken to employ and train a clinical workforce and those sorts of things. Pleasingly, we are starting to see some of those numbers reduce, even in that time since we were able to provide you with numbers for the period we were in. If Ms Blackwood has the figure, she'll be able to tell you.

Ms Blackwood: As at the end of September, there were 116,339 referrals for aged-care needs assessments on hand. This comprised approximately 40 per cent waiting for a home support assessment, which is typically the pathway to Commonwealth Home Support Program services, and approximately 60 per cent awaiting a comprehensive assessment.

Senator ALLMAN-PAYNE: Is it true that the department has abandoned KPIs for wait times for assessment agencies?

Mr Pugh: No, we haven't abandoned them.

Senator ALLMAN-PAYNE: Have they changed?

Mr Pugh: They haven't changed.

Senator ALLMAN-PAYNE: Have they been temporarily waived?

Ms Blackwood: We have indicated that, during the initial transition to the Single Assessment System workforce, we won't be enforcing those KPIs for approximately the first 12 months of the system.

Senator ALLMAN-PAYNE: Is there a national priority list for assessments?

Mr Pugh: Not in the same context as the Home Care Packages Program, no.

Senator ALLMAN-PAYNE: Okay. I'm interested to know how long people are waiting for assessments. The Older Persons Advocacy Network report said that they're advocating for people who are waiting 10 weeks just for a response from an assessor, and then nine to 12 months before they actually hear back from them. Can the department confirm whether those numbers are correct?

Ms Blackwood: I can speak to the median wait times for assessments, which we have seen trending down in the last few months. The latest data that I have is that, in September, the median wait time for comprehensive assessments was 42 days, the median wait time for home support assessments was 19 days and the median wait time for hospital assessments has continued to be one day.

Mr Pugh: Also, we spoke at the very start of this hearing about the accuracy of the data that we pulled being the most recent. I just want to be clear for the record that those same caveats apply to what we've just talked about as well.

Senator ALLMAN-PAYNE: Thanks, Mr Pugh. In terms of numbers, as opposed to percentages or medians, how many people are waiting more than a month for an assessment?

Ms Blackwood: I'd need to take that specific question on notice.

Senator ALLMAN-PAYNE: Okay. Can I also get on notice then, too, how many people are waiting more than six months?

Mr Pugh: Yes.

Senator ALLMAN-PAYNE: Could you also take on notice the median time to get an ACAT assessment in each year over the past five years?

Ms Blackwood: Yes. Just to clarify, 'ACAT assessment' is not a term that we're using under the Single Assessment System. We're talking about 'comprehensive assistance'.

Senator ALLMAN-PAYNE: If you want to go from ACAT and then to comprehensive, as it's changed, that's fine. Could you also give us a breakdown, on notice, with the average wait times for each jurisdiction—so by state and territory? At the moment, what is the current monthly capacity—

Mr Pugh: Sorry, Senator, I didn't mean to cut you off. I will just check, because we did provide some data in advance to Senator Ruston. I'll just make sure we haven't already taken that specific—

Senator ALLMAN-PAYNE: If you have already, I'm happy to find it there.

Mr Pugh: I'll establish that we haven't.

Senator ALLMAN-PAYNE: I'm happy for you to check that. What's the maximum monthly capacity at the moment for comprehensive assessments? What's the greatest number of comprehensive assessments that can be done at the moment in a month? Do you have a measure of that?

Mr Pugh: I'll have to take that one on notice as well.

Senator ALLMAN-PAYNE: Yes, that's fine. An open tender process began in early 2024 for organisations to deliver age-care assessments for the Single Assessment System. What percentage of tenders were provided to private providers?

Ms Blackwood: The overall approach was that 40 per cent of the market share would be provided to state and territory providers, with the balance to go to private providers.

Senator ALLMAN-PAYNE: What's the rationale for privatising the assessment system?

Mr Pugh: It's just to ensure that we've got significant national coverage. I wouldn't say that we're privatising it, either. There is a mix between private and state and territory administered providers, and some of the states and territories actually sit in both categories.

Ms Blackwood: That's right, and the mix existed prior to the establishment of the Single Assessment System. There were private providers doing regional assessments, for example.

Senator ALLMAN-PAYNE: What qualifications do the private providers need to do those assessments?

Ms Blackwood: We have different qualification arrangements for clinical assessors and non-clinical assessors, and different qualification arrangements depending on your role within the system—so triage delegates, decision-making delegates and those sorts of things. I can take the details of that on notice.

Senator ALLMAN-PAYNE: That would be great, thank you. I'm also interested to know what assurance the department seeks regarding the quality of the assessments, because we're certainly hearing from people that they're concerned about the quality.

Ms Blackwood: We have implemented a program of quality assurance measures as part of standing up the Single Assessment System program. Initially this kicked off in January this year with a focused desktop analysis of support plans produced by assessment organisations. We've done a couple of rounds of that assessment process, and we're feeding those results back to assessment organisations as well as into our program management activities.

Senator ALLMAN-PAYNE: Do you know what percentage of assessments are currently being done by phone rather than face-to-face?

Mr Pugh: Yes. Since the commencement of the single-assessment system in December, we have seen, between then and 31 August, around 32 per cent being undertaken by telehealth. That can be either teleconference or via videoconference.

Senator ALLMAN-PAYNE: On this line of questioning, and then I'll pass the call: before you moved to the single-assessment system, what was the percentage of assessments that were being done by phone?

Ms Blackwood: It was only slightly less than that 32 per cent figure that Mr Pugh indicated. I don't have the specific figure to hand, but we can take that on notice.

Senator ALLMAN-PAYNE: If I could get that on notice, please.

Mr Pugh: I'll just add as well that, obviously, face-to-face is preferred, but, while we are in the situation where we've seen improvements over the recent months—we do have quite a number of assessment referrals on hand—we are trying to make a balance between the face-to-face and the telehealth components. That is simply to get as many people assessed as we possibly can.

Senator ALLMAN-PAYNE: I understand that. The concern that some people have is that, when those phone assessments aren't correct, we're having to re-do the process.

Mr Pugh: We understand those concerns. We're working on them.

Senator ALLMAN-PAYNE: In relation to the tenders for the provision of those comprehensive assessments, was it a requirement of that tender process that the majority of assessments have to be done face-to-face? Is there an actual requirement in that process, or is this just how it's rolling out?

Ms Blackwood: There is a KPI that 95 per cent of assessments be conducted face-to-face in non-remote settings and 50 per cent in remote settings.

Senator ALLMAN-PAYNE: Those are the same KPIs that are not being held to for the first 12 months. Alright.

Mr Pugh: I'll add as well that we're not taking a completely hands-off, lax approach to it. We are monitoring closely those providers or those assessment organisations that are not meeting KPI and working with them closely to make sure that they are actually doing the best that they can to get as close as they possibly can to KPI.

Senator ALLMAN-PAYNE: Great. I'll hand over the call.

CHAIR: Senator Ruston.

Senator RUSTON: Can I ask some questions on the star-rating system, please. There are some changes that came in on 1 October in relation to the star rating, particularly as they related to the staffing sub-rating and the system. It now appears to me that, if a provider misses their target of their 24/7 or if they miss their target of their care minutes by one per cent, they will automatically get a one-star rating. Is that correct?

Ms Laffan: To clarify, 24/7 is not a component. The two components that I think you're referring to are the total number of care minutes and the RN minutes.

Senator RUSTON: So, if they miss the care minutes on both accounts by the smallest of percentages, then they will automatically get a one-star rating. Is that correct?

Ms Leonard: You are correct. From 1 October this year, there are changes to the way the staffing rating will feed into the overall star rating for a residential aged-care service. What those changes require is that services will be required to meet both their total care minutes and RN care minutes in order to achieve three or more stars for the staffing rating.

Senator RUSTON: To confirm: if you miss both of those, even by the smallest component, you will automatically be put on a one-star staffing rating?

Ms Leonard: No. That's incorrect, Senator. If you give me a second, I will—

Ms Laffan: Depending on the percentages, you may reach a two-star rating or a one-star rating.

Senator RUSTON: Well, not according to your figures here. If you miss both of them—if you are below 100 per cent on your total care minutes and below 100 per cent on your RNs—you will get a one-star rating.

Ms Leonard: In the instance where a service does not meet both of their care requirements—total care requirements and RN requirements—then a one-star rating will apply for the staffing rating.

Senator RUSTON: That's what I just asked you.

Ms Leonard: But, where a service may meet one of those requirements and not the other, then there is a two-star rating.

Senator RUSTON: But Ms Laffan just said to me that wasn't what you were saying.

Ms Laffan: Apologies.

Senator RUSTON: So, if you miss by the smallest amount on both of them because somebody rings in sick or the like, you will actually be dropped to a one-star rating. How much consultation was undertaken with the providers before the changes to the star rating occurred? Particularly in the context of—

Mr Comley: Sorry, I'm just clarifying with my colleagues. That's the star rating for that component of the star rating, and that component makes up one of five.

Senator RUSTON: Yes, I understand that, Mr Comley. I'm talking about the subcategory of staffing.

Mr Comley: I'm just concerned that people might be listening and think you go to a one-star rating for the whole, overall rating.

Senator RUSTON: I'm pretty concerned about what people are thinking about your star ratings anyway, and I think they should be extraordinarily concerned. The public perception on a rating scale is that, if you meet your requirements and, in this instance, even meet your requirements in a workforce constrained environment—and we know how difficult this has been—or even if you exceed all of your requirements, you may only get a three-star rating. Now, I think most people would suggest a three-star rating is pretty middle-of-the-road. It's not particularly good. It's not the worst it can be, but it certainly ain't the flashest it can be. But, even if you exceed your minutes, you still could possibly only end up with a three-star rating. Is that correct?

Ms Laffan: Again, just to clarify and as you mentioned, I think what you've got in front of you is a matrix that's available as part of our program guidelines. I think there's a difference between whether you're above in both or whether you're above and meeting the requirements in both. It's a matrix in terms of the assessment.

Senator RUSTON: Ms Laffan, if you meet both of the requirements that have been outlined by this agency as to the requirements to meet your staffing requirements—you don't exceed them but you meet them both—what star rating will you get?

Ms Laffan: Three stars.

Ms Leonard: You'll get a three-star rating for your staffing subcategory, and that reflects an acceptable rating. When the department undertook a consultation with the sector and with older Australians, families and other stakeholders last year, this was a matter that was, in fact, very well-supported. The current star rating matrix has an inbuilt tolerance, and that reflects significant workforce challenges across the sector at the time the star ratings program was established back in 2022. There has been significant improvement in a number of measures to support services in meeting workforce shortages. Within that context, as I said, this issue was consulted upon, and it was broadly supported to make these changes to reflect that a service needs to meet both of their care minute requirements in order to achieve three stars.

Senator RUSTON: Could you provide that consultation paper so that we can understand who you consulted with that said three stars was the public expectation in terms of meeting the requirements that you put forward. You made the comment on the issue in terms of staffing. It would appear to me, by this, that if you are forcing aged-care homes to use the staffing minutes as a means by which to determine care and not looking at other innovative ways—tell me, how do you measure quality care?

Ms S Stewart: Can I make a comment just before Ms Laffan answers that question. I think it's important—and I'm not sure where Ms Harper is—in terms of the star ratings and in terms of this focus around quality and this focus around staffing that there has also been a very considerable investment in terms of fair work and wages to assist providers in meeting that requirement.

Senator RUSTON: I'm actually coming to that in a minute, Ms Stewart. I'm keen to understand. We've got a situation where, despite the fact that we have certainly seen an improvement in workforce accessibility, there are

still challenges, particularly in markets outside of metropolitan areas. You are actually requiring residential aged-care providers to have more care minutes in order to achieve a five-star rating. You are requiring them to have more RNs and more care staff than the benchmark that you set for them. In fact, even if they exceed both their RN and their care minutes, in many instances, they may still only get a four-star rating. That's even if they exceed the benchmark that you set for the sector. In a workforce constrained market, you are actually incentivising some providers to have more staff and more RNs. When we know that we're struggling with RNs, in terms of the general care community, you're actually putting incentives in place so that they've got more care minutes than you've assessed that they need. I just don't understand why you would be doing that in a workforce constrained market. I don't understand how this is helping people navigate a system, when they go on and see that an aged-care home has got a three-star rating for staffing when they've actually met the benchmark that you set for them. It just makes this whole thing a complete mockery.

Ms Laffan: A three-star rating means that the service is meeting its requirements. That's the definition of three stars.

Senator RUSTON: They are requirements that you set for it in a workforce constrained environment. When we are screaming out across the entire care workforce for RNs, you're incentivising homes to have more RNs on than you yourselves have set as the benchmark, the standard, for the quality of care that you believe is appropriate. You're incentivising them to have more RNs and more carers when some people are screaming out just to get those carers and those RNs. It makes no sense to me at all.

Ms Laffan: I would have to get my colleagues who deal with the actual requirement. A benchmark is not a ceiling. That's a floor. That's a requirement, that they have at least that number of care minutes.

Senator RUSTON: So, basically, you're setting things at mediocrity. Is that what you're telling us?

Ms Laffan: No. We're saying that that level is the base requirement.

Mr Comley: I've sat through estimates on this in, I think, the last year and a half where we were being criticised, not long ago, for allowing people to get three-star ratings when they weren't meeting their benchmark. In the consultation, as you've heard the officer saying, the sector wanted to have those incentives for higher quality care.

Senator RUSTON: I look forward to seeing that consultation.

Ms S Stewart: I think the other important thing to note here, and if one of my colleagues can assist me, is the data that I have is that the sector is actually responding to this, in terms of 24/7 and the percentage increase. My notes say that in July 2023 there was 86.03 per cent of providers reporting facilities around the 24/7 registered nurse coverage, and in August 25 it was 95.66 per cent, so I think that that's important, in terms of nobody wants to go backwards in quality. People want a system that they can understand, in terms of older people, their family and their kin, and the sector is responding, in terms of that workforce and the importance of that care, by registered nurses 24/7 in those minutes.

Senator RUSTON: Okay. Moving on, I am wondering, Minister, whether you are aware of a case in South Australia that was reported yesterday in relation to an aged-care home that is run by Disability SA at Northgate in South Australia.

Senator Green: I'm broadly aware of the media reporting, but, if you've got some specific questions, I can answer them.

Senator RUSTON: We've just heard that, even if you're meeting the requirements that have been set by the department in relation to staffing, you only get three stars. This facility has had some very serious accusations made against it in relation to constraints, but this facility was operating under a four-star rating. How does that play into the reasonable expectation when people go on and have a look at the star ratings? You've got a home that's meeting its care minutes and could be exceeding its care minutes that has only got three stars, and you've got a home where there are some very serious accusations in relation to using mechanical restraints and they've got a four-star rating. How does that play out?

Ms Laffan: I'd have to check the details as to whether they currently have that four-star rating and what their history of that rating was. But what I would say is that one of the elements f start ratings—an element that's updated daily—relates to compliance action taken by the commission. That does vary in accordance with any notices and regulatory action issued by the commission. They may have returned to compliance. As I said, I'd have to look at the current details and also the history of the start ratings for that organisation.

Senator RUSTON: Okay. I'd be keen to hear what you've got to say. I'd also be very keen to understand: are any of the residents or former staff of Oakden, the facility that was closed down in 2018 in my home state of

South Australia under some pretty horrific conditions. Are any of those people either in this home or in the staff working in this home?

Ms Hefren-Webb: The team that has undertaken the work at that facility—I don't believe we've checked whether the same people might have come from the former Oakden. I'm not sure that we would have that knowledge. But I can follow that up for you.

Senator RUSTON: Thanks. It appears from the information contained here that this particular home had four times the RN minutes required. They might well have gotten five stars for their staffing, but they were actually using constraints that quite clearly they shouldn't have been using. Star ratings are great if they're actually providing a clear story so that the average layperson, going onto your star rating site, can get the true picture of the quality of care being delivered by that particular home. But I would contest, on the basis of the question here, that nobody would have any idea. There seems to be a complete disconnect between quality care and the star rating system that you've put in place. Ms Hefren-Webb, do you believe that this particular case should have been exposed in the interest of transparency, given that a major component of the implementation of this was in relation to star ratings? Do you think this information should have been disclosed earlier?

Ms Hefren-Webb: Senator, as you know, the issues were identified when staff from the commission undertook a monitoring assessment in late May. Our approach is always to work with the provider on rectifying the matter and giving them the opportunity to make improvements. We've been doing that. Our primary concern, a you're aware, is the safety and wellbeing of the older people in the facility. We've been working with the facility on a very close basis. They've appointed additional clinical staff, and they have not been taking any additional residents since we engaged with them. The families of those residents have been informed about the issues and the actions. There have been residents' and family meetings. The people who are most affected by this have been kept well informed. There was no likelihood additional people would enter the facility. Obviously, if we take formal action, that is made public. But our goal is to bring people back to compliance as quickly as possible. That has been the basis on which we've been working with them.

Senator RUSTON: Sure. It is alleged in the media that you were aware of these issues in November last year. Is that correct? Or is that just media speculation?

Ms Hefren-Webb: I might ask Mr Rake to talk through the timeline.

Mr Rake: We were aware of a different set of issues in November last year, and those were made publicly available in an assessment report published on our website. That is still available today.

Senator RUSTON: What were those concerns in November?

Mr Rake: In November, we identified that there were three standards where they were showing noncompliance—this is publicly available on our website: against standard 3, personal care and clinical care, around risk assessment for consumers; standard 7, human resources, around training of the staff; and standard 8, organisation governance, around having an appropriate clinical governance framework.

Senator RUSTON: You identified those in November, and then a subsequent audit in May identified the restraints and mechanical issues—

Ms Hefren-Webb: It was an unannounced visit.

Mr Rake: It was an unannounced visit, which is a slightly different category to an audit.

Senator RUSTON: Sure, I understand. Nonetheless, it's still a very serious and concerning thing. Of course, that's what your job is. So you identified those in May. Unless it's changed in the last day or so, this particular home still held a four-star rating this week. Could somebody explain to me in terms of the star rating system how on earth, given we have found out that there were compliance issues in November, publicly published, there were mechanical restraints issues identified in May and yet in October this home had a four-star rating? How can you honestly say that a star rating system is providing people who will go onto that site with accurate information as to the quality of care that is being delivered by a home on the basis of your star rating system?

Ms Laffan: I'd have to take those particular circumstances on notice.

Senator RUSTON: Thank you. Can I just ask about ANAC funding—the recent uplift in ANAC funding?

CHAIR: I will share the call, if that's okay, to Senator Allman-Payne—

Senator RUSTON: Yes.

CHAIR: and I'll come back to you.

Senator ALLMAN-PAYNE: I note that the aged-care royal commission recommendations included a recommendation for a separate aged-care pathway for Aboriginal and Torres Strait Islander people as well as

block funding for providers delivering services to support people's connection to country. I'm just wondering if you can give me some information around what the government has done to progress the development of an Aboriginal and Torres Strait Islander pathway.

Ms Harper: Certainly. I'll ask Ms Tatipata to talk through this in a little bit more detail for you.

Ms Tatipata: In terms of the cultural pathway, there are a number of initiatives. I spoke earlier about the National Aboriginal and Torres Strait Islander Flexible Aged Care Program. There's work underway to support transitioning those providers. There are 49 providers currently, and they're being supported to transition under the act. We've engaged an organisation to work with them and provide a range of supports around face-to-face training, resources and ongoing support over the next two years. Also, there are things happening in the assessment space. We are working now with our pilot around building out First Nations assessment organisations. That pilot is commencing, and we'll work with those providers to deliver home support and comprehensive assessments. We will work out the things that work and what needs to be built on as we build out and introduce more assessment organisations into that space as well.

Ms Harper: If I may just follow up very briefly on that, there are currently three organisations that have been engaged by the department to participate in phase 1 of the pilot. It should be acknowledged we're really keen in this process to absolutely get it right, and that means piloting and learning from that pilot to expand and also build capacity of organisations in undertaking these assessments and interacting with the single assessment system that we heard a lot about earlier this evening. That is progressing, it's progressing well, and we're obviously really excited to see the outcomes.

In those pilot organisations, drawing on your earlier line of questioning around the rural and remote as well, it is really important to note that we do have a mix of organisations servicing urban, older First Nations Australians as well as those in rural and very, very remote Australia. We're really keen to understand and learn from the experiences and the service offerings—and the challenges, obviously, but, really importantly, the opportunities—as we look to expand the program moving forward.

Senator ALLMAN-PAYNE: Good. How many providers are predominantly Aboriginal and Torres Strait Islander run and are staffed with predominantly First Nations carers? Do you have any figures on that and on whether that's increasing, or are you waiting on the pilots to—

Ms Harper: For the assessment organisation specifically?

Senator ALLMAN-PAYNE: No, this is for care providers.

Ms Tatipata: It will depend, because there are a range of First Nations organisations working in different programs under Support at Home. I think that, with the First Nations sector, we are working closely with the Aboriginal community-controlled organisations. For example, in the Indigenous Employment Initiative that we spoke about earlier, there are currently 50 Aboriginal community-controlled organisations working with us. With NATSIFAC, the work we're doing with NACCHO, they're all Aboriginal and Torres Strait Islander community-controlled organisations. There's a real commitment to ensure that we're working closely with the sector and to ensure that we continue to build on and increase that, because we understand that that is what works for the communities in terms of cultural safety.

Ms Atkinson: Just to add to Ms Tatipata's answer, the government did have a growth round in the Commonwealth Home Support Program last financial year that was specifically targeted at Aboriginal community-controlled organisations. It was $10 million and 18 organisations were funded. These were new organisations to the CHSP and it was specifically to increase that representation of Aboriginal community-controlled organisations in that program.

Senator ALLMAN-PAYNE: In terms of dedicated First Nations provision of care, are there First Nations providers across CHSP, home-care packages/Support at Home and residential aged care, or do they tend to be concentrated in one of those areas of care at the moment?

Ms Atkinson: I think we would say it does vary, but we'd probably take the specifics on notice.

Senator ALLMAN-PAYNE: Okay. I'm very interested to understand which parts of the care system they're in.

Ms Harper: There absolutely are service providers that provide NATSIFAC services, for example, and some of those also provide home care and some of them operate in residential. There is a broad mix, and, as Ms Atkinson has pointed out, there is growth and a focus on ensuring greater representation. I think it would be highly variable across the country.

Senator ALLMAN-PAYNE: Thank you.

Ms Tatipata: Can I just correct something that I said.

Senator ALLMAN-PAYNE: Yes, absolutely.

Ms Tatipata: For NATSIFAC, it's 49 service providers. The 97 that I was referring to were elder-care support organisations. Apologies for that.

Senator ALLMAN-PAYNE: No, that's fine. Thank you. I note that we have an interim Aboriginal and Torres Strait Islander aged-care commissioner. I'm just wondering where plans are at to make that commissioner permanent?

Ms S Stewart: Ms Kelly isn't with us today, unfortunately. We'll take that question on notice.

Senator ALLMAN-PAYNE: Do we know if there is a plan and a timeframe to make that permanent?

Ms S Stewart: We'll take that question on notice.

Mr Comley: To be clear, it's a question about the position and not the individual?

Senator ALLMAN-PAYNE: Yes, that's right.

Ms S Stewart: Sorry.

Senator ALLMAN-PAYNE: It's late. My brain is fried too.

Ms S Stewart: Thank you, Secretary. I'm an early riser, so this is not my peak time.

Senator ALLMAN-PAYNE: You and me both, Ms Stewart.

Ms S Stewart: I apologise.

Senator ALLMAN-PAYNE: That's totally fine.

Ms S Stewart: The government has a commitment for a First Nations commissioner for aged care to ensure proper access and quality for First Nations people across Australia.

Senator ALLMAN-PAYNE: I think that's great and I understand that. The question I'm interested in, which you may have to take on notice, is: is there a timeframe to actually make the position—not the person in the position but the position—permanent, and is that going to happen sooner rather than later? That's what we want to understand.

Ms S Stewart: I'm happy to take that on notice. There is a plan. There is the need for legislation and there is a plan to make that happen. I note that, at the moment, that there is an interim First Nations commissioner, Andrea Kelly, who is undertaking that role in the interim.

Senator ALLMAN-PAYNE: I can't imagine a situation in which there wouldn't be cross-parliament support for that legislation, so I would encourage the government to bring it on.

Senator Green: We will have more constructive work around the parliament to achieve these reforms, including with the commissioner.

Senator ALLMAN-PAYNE: I understand that VACCHO has written to the minister raising concerns about the impact of proposed changes to aged-care charging arrangements on Aboriginal and Torres Strait Islander peoples. VACCHO CEO Dr Jill Gallagher AO set out these concerns in an article on the Croakey health and aged-care policy website. That has been given to the committee in case it needs to be tabled. In that, Ms Gallagher said:

Non-Indigenous Australians become eligible for aged care services at the same time as they can access their superannuation. But Aboriginal people, who access aged care services from the earlier age of 50, will face up to 15 extra years of paying fees and co-contributions for aged care services—before reaching the age of access to their super.

Is that a correct characterisation of the situation that many First Nations people find themselves in?

Ms S Stewart: I would acknowledge the expertise of Dr Gallagher and VACCHO, and I also speak as an Aboriginal person. What we are aiming to do is ensure that Aboriginal people get access to services in a timely manner. The strategy is twofold. One of them—and you would have heard my colleagues talk about it—is to grow the workforce, grow the Aboriginal sector. The second part, which is very important, is to ensure that non-Aboriginal-and-Torres-Strait-Islander services deliver quality in a culturally and trauma informed way. That is the process to do that.

In terms of Aboriginal people and paying their contribution, I'll leave it to Ms Trainor to make any specific comments around that. Once again, this system is built so that people who can pay should be paying, and so that the fees are set at a rate where people are able to access the quality and the care that they need. Ms Trainor, do you have anything further to add?

Ms Trainor: My observation is that the contribution regimes are the same for First Nations participants as they are for all other participants in both the Support at Home program and the residential aged care program. There is no difference in those. There are elements like the lifetime caps that protect people who are in the system for a very long time, but any decision to do anything other than treat all participants on the same financial basis would be a decision for government.

Senator ALLMAN-PAYNE: Has the government given any consideration to accounting for the fact that First Nations people are eligible for care a lot sooner and, therefore, are potentially in the system for a lot longer, and the fact that, for example, they can't access super like older Australians can?

Senator Green: These concerns have been raised with the minister. He consults with, particularly, the aged-care sector as well as First Nations stakeholders. He's taking the concerns very seriously. What we're committed to do as a government is to closely monitor the impacts of the new policies on First Nations Australians so as to look at if there are any additional impacts we need to be aware of. That's the work that we'll continue to do when the new system comes in.

Senator ALLMAN-PAYNE: Dr Gallagher also said:

For generations, my people were forced into poverty by government policies that excluded us from the workforce. Even when work was available, we were often paid in food rations, tobacco, or not at all. Our wages were stolen. Our super was never paid.

Now, the Government will be forcing those generations to pay out-of-pocket fees for essential home support like meals, cleaning, transport, and personal care.

Is there a fundamental equity issue there?

Senator Green: Was the question to me? I thought you were asking the officials.

Senator ALLMAN-PAYNE: I think it probably borders on opinion, Minister, so I think I have to direct it to you.

Senator Green: I think the royal commission was really clear that First Nations people, when it comes to aged care, have poor experiences and that there is an enormous amount of reform needed. There is—as you would know, having spoken to officials today—an enormous amount of work, and, it pains me to say, a lot of investment that we've committed to support First Nations elders in this transition to a new, reformed system. That particularly includes the National Aboriginal and Torres Strait Islander Flexible Aged Care program, ensuring we're delivering culturally safe care to elders around the country.

Senator ALLMAN-PAYNE: There's been a lot of talk tonight about 'culturally safe', and I think that's really important. What Dr Gallagher is highlighting is this significant equity issue, and the question is: given that the government has committed to closing the gap, is there more that the government can be doing to address this fairly significant issue, particularly for those people who've had, for example, wages stolen?

Senator Green: I can't add to my previous answer. Concerns have been raised with the minister, and he is taking them very seriously.

Senator ALLMAN-PAYNE: I understand that there's an exemption for payments made under the National Redress Scheme for Institutional Child Sexual Abuse Act 2018 to contribute towards the residential-care assets test. That is welcome and is a good thing. One of the questions that have been raised is why there is only an exemption for that particular redress scheme rather than also for reparations given to survivors of the stolen generations. Is the government open to considering including reparations given to survivors of the stolen generation in the exemptions, as well as the exemption of payments under the redress scheme for institutional child sexual abuse?

Senator Green: I remember these questions coming up as part of the most recent parliamentary debate around the aged-care reforms. I don't have the answer with me. I can take it on notice, or, if officials have some information about how we're approaching that assessment and different payments for the purposes of the assessment, I'm sure they'll provide you with that information.

Senator ALLMAN-PAYNE: One question that constituents have—and, if it's possible for the department to answer this this evening, I'm keen to understand the rationale for treating those payments differently. Why is one form of redress included but the other isn't?

Ms Trainor: It was a decision of government to specifically exempt those National Redress Scheme payments from the residential-aged-care assets test. It's only for residential aged care and not for Support at Home. That was reflecting advocacy from the national roundtable on redress and other advocacy groups. Any decision to extend that to other redress schemes or apply that to other programs would be a matter for government. I do note that

there was some discussion of this when the ACOLA Bill was considered by parliament. There was an observation made there about the relationship to the pension system, where neither of these schemes has any kind of exemption treatment, and the value of a whole-of-government consideration.

Senator ALLMAN-PAYNE: Maybe, on behalf of constituents who have raised this with us, I could ask the minister again to consider including stolen generations reparations, particularly as it's a way to close that equity gap that we know exists. How am I going for time?

CHAIR: You've got about three minutes.

Senator ALLMAN-PAYNE: I'll give you a couple of questions on notice from earlier, then I'll go to Senator Ruston and then do my last lot. Due to the significant backlog in wait times for both comprehensive assessments and home-care packages, could you tell me, on notice, how many bed-nights are currently being used for older people in hospital who don't need hospital care? I note that WA, for example, has given some numbers. I'd appreciate it if this data could be provided broken down by each state. And could we get information on how many older people are in hospital in a bed that they don't need for care, because they're waiting for other care. The second question on notice: could we have data on waiting times for comprehensive assessments in hospitals versus waiting times outside of hospital via the new assessments and how many people are in hospital waiting for an assessment.

CHAIR: Senator Ruston.

Senator RUSTON: Can I ask some questions in relation to the recent AN-ACC funding increase. How much was the uplift in the base AN-ACC price in the most recent determination on 1 October?

Mr Richardson: The price moved from $282.44 to $295.64, an increase of $13.20.

Senator RUSTON: And that's where you got to the 4.67 per cent.

Mr Richardson: Correct.

Senator RUSTON: Over the next period, before the next time that we have an AN-ACC increase, has the government budgeted to actually pay 4.67 per cent more than they are currently paying?

Mr Richardson: The short answer is yes; it's budgeted for. Any updates to the estimates and so forth will be published with MYEFO. To go into a little bit more detail with weight changes and so forth associated with AN-ACC, which I'm sure you're aware of, the overall increase in AN-ACC funding is equivalent to about 3.3 per cent.

Senator RUSTON: The headline in the press release was 4.67 per cent, Minister, and yet the increase was only 3.3 per cent. Do you think it's misleading to say it was 4.67 per cent when the reality is, because of the change to the NWAU, it is actually only 3.3 per cent?

Senator Green: The figure I've got in front of me is the 3.3 per cent. I can take on notice if that press release was referring to a different model.

Senator RUSTON: No, it's not. It's referring to the same thing.

Senator Green: I can take it on notice for you.

Senator RUSTON: The sector was issued—and it was on the department of health and aged care's website that the government had provided a 4.6 per cent uplift in funding, which really only related to the increase in the base AN-ACC funding and took no account for the fact that they had changes the weighting of the various classes that sit within AN-ACC. How much of the new AN-ACC price is attributable to the Fair Work Commission's pay increases that'll occur in the future funding period?

Mr Richardson: How much of the price?

Senator RUSTON: Yes.

Mr Richardson: $8.46.

Senator RUSTON: On your website, it says that the increase in AN-ACC funding per bed on 1 October would be roughly an increase of $10. Is that correct?

Mr Richardson: Correct. With the weights and so forth, as you're clearly aware of, you multiply the weights by the price to get your overall funding. Before the 1 October changes, average funding was about $305.99. That has increased, we're forecasting, to $316.

Senator RUSTON: So that's a $10 increase, give or take a cent.

Mr Richardson: Correct.

Senator RUSTON: You just said that $8.46 was attributable to the Fair Work Commission pay rise.

Mr Richardson: Yes, of the price of $295.64.

Senator RUSTON: I'm just trying to understand how much is left over after you take out the fair work pricing increase. How much is factored in to items not related to the Fair Work Commission determination?

Mr Richardson: I'd have to take those details on notice. As I'm confident you are aware, the indexation of the price includes things like changes to superannuation and the annual award wage increases. It also takes into account changes for other elements of care funding, such as allied health, corporate overheads, HR, financial management, medical consumables and all those sorts of things.

Senator RUSTON: I'm just trying to understand. The government made a commitment that it would fully fund the Fair Work Commission determination. It appears as if the increase in the absence of that particular amount is significantly lower than would be the cost of the other increases that have been incurred by the sector. You said superannuation, so that's gone up by 0.5 per cent. My understanding is that the general projected wage growth is about 3.75 per cent. There's obviously health inflation more generally. I'm keen to understand, after the uplift in AN-ACC, which is actually only 3.3 per cent, do you believe, or does the department believe, that the providers will be better off or worse off? It would strike me that they can't possibly be better off; in fact, they must be worse off.

Mr Richardson: A couple of things. The objective is cost based pricing. The government's policy is that the costs associated with care and also everyday living—I think that probably comes into the conversation—are fully funded. So I wouldn't describe—

Senator RUSTON: I'm just talking about AN-ACC. I absolutely respect what you're talking about, Mr Richardson. I'm a hundred per cent on those other parts. I'm sort of just trying to get an understanding around the AN-ACC funding. One of two things appears to have happened here. Either the government hasn't fully funded the wage increase, or the government hasn't recognised the increase in the cost of doing business and all the other cost burdens on business that an aged-care provider would face.

Mr Richardson: I hear what you're saying. It's cost based pricing, so it is fully funded. I wouldn't describe it as being better or worse off. The reason I raise everyday living is that there was a 42 per cent increase in the hotelling supplement—up to $22.15 from $15.60. When you take that collectively, it's a 5.1 per cent increase in funding for the sector across both of those funding streams.

Senator RUSTON: Is Professor Pervan here?

Ms Trainor: I think Professor Pervan is online. I note that IHACPA provides advice to government on the appropriate levels of AN-ACC. He's just popped up on the screen now.

Senator Green: While we go to the teleconference, can I just correct something? You said the minister's media release had a 4.6 per cent increase.

Senator RUSTON: Yes, it was online.

Senator Green: It doesn't refer to 3.3 per cent, but it doesn't refer to 4.6 per cent either.

Senator RUSTON: It's on the website.

Senator Green: No, I'm not sure what you're referring to, but the media release in relation to the AN-ACC change in price, which was on 12 September, doesn't refer to a different percentage figure.

Senator RUSTON: Senator, the uplift in the base AN-ACC price is 4.67 per cent, and that was blazoned all over all the communications at the time.

Senator Green: You said it was in a media release. It wasn't.

Senator RUSTON: It was on the website. That's how I found it.

Senator Green: I'm clearing that up for you, just to be clear, because I don't want the minister misrepresented. The media release doesn't say that.

Senator RUSTON: The minister made it very clear on his website that it was a 4.67 per cent increase. That was correct as it related to the base AN-ACC price. It was not correct in the additional amount of funding that was being provided to the sector.

CHAIR: Senator Ruston, are you able to table that document?

Senator RUSTON: Sure. I'll get someone to download it for us.

CHAIR: Great.

Senator RUSTON: Back to Professor Pervan: I'm keen to understand, as you sit here now, if you are confident that you've got the necessary information in order to make the pricing determinations that you need in order to provide pricing both to residential and home care over the coming year.

Prof. Pervan: Good evening, everyone. In terms of confidence, we've touched on this conversation before. Yes, we are confident that the pricing advice we provided to government reflects the costs that we gathered that were reported to us by over a hundred providers. Yes, it does look a bit odd in respect to what you would expect, but we have been back. We've QAed all of these results. This is certainly what the cost report and the cost analysis are showing are the costs of these services.

In terms of why they're moving in this direction, that would be something that would have to be subject to a bigger study. But, when you have a look at the ANAC increase and the adjustment to the class weights alongside, as Mr Richardson pointed to, the hotelling costs—if you look at them collectively—that looks more like what you'd expect to see in the environment of residential aged care. But we are expanding our cost collection, as I've said before. We're very keen to learn more about specialised and rural and remote services. We would expect to see costs differentiating from metropolitan areas, and they do, but, once again, not to the extent that you would expect. We're confident that this is reflected in their current costs.

I think one of the things that emerged out of my contact with the sector recently is that there's still some learning to do around what an activity based funding environment looks like, particularly when your resident population is changing in terms of their complexity. People who received a particular level of revenue last year because they had some very high ANAC-class residents have lower ANAC-class residents this year, so they're projecting lower revenue. Now, the department has all sorts of means of supporting people through that process. In terms of your specific question, I'm confident that the pricing advice we provided to government does reflect their current costs, but we are monitoring that very, very closely to make sure that there's no volatility coming through the system that we didn't pick up on in the costing study.

Senator RUSTON: That's fine. I quite understand. You've only been the aged-care pricing authority for a short period of time. Nobody is expecting you to have all the data right away. To jump back to the department again: am I correct that NACA, the National Aged Care Alliance, prepared a discussion paper on the state of the aged-care-form process?

Ms S Stewart: I think we'd have to take that on notice. Do you know, Susan?

Ms Trainor: I think we'd have to take that on notice.

Senator RUSTON: You don't know whether there was a discussion paper. My understanding is that a discussion paper is actually with you. It's required as part of an acquittal process that it has to be provided to you, and it was provided to you in June.

CHAIR: I think the officials have taken that on notice. So we will endeavour to get you an answer back by, hopefully, the end of the evening.

Senator RUSTON: That would be great because I'd be really interested to understand if it is going to be publicly released—

CHAIR: We'll see what we can do.

Senator RUSTON: and whether members of NACA have been able to get a copy of that report. As Senator Allman-Payne said, there was a large number of people who, we are hearing, are occupying people who are waiting for aged-care or disability accommodation. There is a growing number in hospitals et cetera. I'm keen to understand. The aged care data for 2024-25, was posted, I think, reasonably recently. Can you tell me what the growth in the number of aged-care beds was in 2024-25 in comparison to the previous year?

Ms S Stewart: Can I just correct that I am aware of that paper.

CHAIR: So it is with the department, just to clarify, Ms Stewart?

Ms S Stewart: That's correct. Thank you for letting me clarify that.

Senator RUSTON: Are you aware whether it's going to be publicly released?

Ms S Stewart: I'll take that one on notice.

Senator RUSTON: Thank you.

Ms Harper: To your question on beds?

Senator RUSTON: Yes, what was the growth in residential aged-care beds in 2024-25? And, obviously, I'd be interested to know what it was in 2023-24.

Ms Harper: Certainly. I might ask Ms Evans to comment.

Ms Evans: The growth in residential aged-care beds for the 2024-25 financial year was 802 places. I would say that, on average, over the last four financial years, there's been a growth of 1,800 per year, so last financial year was lower than previous years.

Senator RUSTON: That 1,800 on average—what period of time does that average out over?

Ms Evans: From 2020 to 2021 through to 2024-25.

Senator RUSTON: Do you know what 2023-2024 was?

Ms Evans: It was an increase of 2,224.

Senator RUSTON: So 2,224, and then it went back to 802?

Ms Evans: Correct.

Senator RUSTON: How does that growth in bed numbers compare with the original expectations of the department as to how many new beds you were hoping or expecting to get in 2024-25?

Ms Evans: You might be referring to some work we did around a growth task. That growth task did not account for growth in beds. It estimated what would occur with demand, based on a current number of beds, so there's no direct comparison for how many were expected to come online to how many actually came online.

Senator RUSTON: What was your expected growth in residents or demand for residency over that same period of time?

Ms Evans: I don't have the demand projection. I know it averages at 10,600 per year in terms of people requiring residential aged care. That's not necessarily a one-for-one, because people come in and out of the system.

Senator RUSTON: How many of those would be additional beds as opposed to those, obviously—

Ms Evans: I don't have that data. I don't have that breakdown, sorry.

Senator RUSTON: Would it be possible to get it?

Mr Comley: That 10,600 number is a forward-looking projection over the next decade, so it's not just the 2024-25 number. The other variable here, obviously, is it depends on what—

Senator RUSTON: What's that period?

Mr Comley: It's basically from now for the next 10 years.

Senator RUSTON: So you think there will only be a need for an additional 10,600 beds—

Mr Comley: Per year.

Ms Evans: On average per year.

Senator RUSTON: Per year, and yet we had 802 this year. And you're estimating that 10,600—

Mr Comley: The number in recent times will not be sufficient to meet that demand if it is maintained going forward. Obviously, the Aged Care Act has only just passed, and the new arrangements commence on 1 November. There are significant increases to provide a viability as a result, including both the RAD arrangements and the changes to co-contributions which support the sector. The other thing, of course, in shorter periods—like the short periods during the last couple of years—that is a significant factor is what's happening to bed occupancy rates, because, if you're not fully at capacity, you can absorb some of those beds before you need the additional new builds. But we would certainly think that we need to get building rates up.

Senator RUSTON: Am I reading between the lines that you believe that the changes that are going to come in on 1 November, as they relate to residential aged care, will see the uplift of that 10,000 beds per year over the next decade, even though, obviously, it will take time for the changes to come into place because there's a lag associated with it? Are you confident that that's the kind of investment? My understanding is that there was a level of quite significant concern about the AN-ACC uplift—even though Professor Pervan is committed very much to believing that the price was right—and that they're saying it's not sufficient. What is the current occupancy at the moment for existing beds around the country, on average?

Ms Evans: Around 90 per cent at the moment.

Senator RUSTON: Ninety?

Ms Evans: Ninety per cent.

Senator RUSTON: Okay. Is that consistent across the country, or do we have some at 98 and some at 50?

Ms Evans: It varies. I don't have those figures in front of me, but I could get them quickly. I'd say there's around a five per cent variation across the country.

Senator RUSTON: How much of that 90 per cent occupancy rate is because staffing requirements are unable to be met and, therefore, they're closing beds because they can't meet their ratios et cetera? And how much of that is just simply because there isn't demand for the beds?

Ms Evans: I'd say that, on occupancy, there are a range of factors which go to whether providers have beds available and whether the beds are being serviced. We know that the official occupancy rate is around 90 per cent, as I said. What we also know is that there are additional beds across the country which may be offline for—I think this is where you're going—

Senator RUSTON: I'm just trying to understand whether the 90 per cent is operational beds or available beds.

Ms Evans: It's based on places and then based on available.

Senator RUSTON: Okay. So—

Ms Evans: There may be some beds that are within that 'available' that are offline because they're being refurbished. We know it's been turnover—beds are being turned over. Going forward, the specifics around whether there are offline beds are something that providers will be required to advise the department on as part of the new Aged Care Act, so we'll be able to have a much more specific figure that takes that into account with occupancy.

Senator RUSTON: Okay. So could you—

CHAIR: Senator Ruston, I'm just checking the time that you need. I need to share the call with Senator Allman-Payne. I can come back to you shortly after the break. I want to make sure that she's able to ask some of her questions.

Senator RUSTON: Okay. Can I just finish that now and draw a line under there. I was keen to understand if you could provide me with information about the difference between operational and available beds and a breakdown in terms of occupancy, because there appears to be quite a difference between your 90 per cent and the 98 per cent that the sector is currently quoting. They count 98 per cent as full because, obviously, there are always going to be changes and transitions that occur. I'm interested to understand why the department uses both of those terms, instead of just using the terms that are used by the sector, because it is a bit misleading.

Ms Harper: We will absolutely ensure that we provide those definitional items as part of it. One of the things that Ms Evans has pointed out that I will stress is that, at the moment, some of these figures—the 90 per cent—are dependent on self-reported data from providers. At the moment, providers, it would be fair to say, are variable in terms of their—they don't necessarily keep us up to date at all times. So there may be a portion of those beds that are offline for various reasons, including capital works, refurbs and various other things to upscale—

Senator RUSTON: It's just quite a big difference—90 per cent and 98 per cent—so I would be interested if we can just try and get an apples-with-apples comparison—

Ms Harper: Certainly.

Senator RUSTON: instead of what we've got at the moment. I'll come back.

CHAIR: Senator Allman-Payne.

Senator ALLMAN-PAYNE: My questions relate to access to residential aged care. The CEO of Uniting NSW.ACT raised the alarm earlier this month when they talked about the fact that entrants to residential aged care who don't have a RAD are disadvantaged over those who do. Essentially what the CEO was saying was that, if you don't have a RAD and you're relying on the supported accommodation supplement of $70 a day to get into residential aged care—can I just check that that is the right amount for the accommodation supplement.

Ms Trainor: Can you just repeat that amount.

Senator ALLMAN-PAYNE: Yes. Sorry, I feel like I'm getting less cogent as the evening goes on. If you can't pay a RAD and you're relying on the supported accommodation supplement, is that $70 a day?

Ms Trainor: There are variable rates of the accommodation supplement. I'll ask Mr Shen to detail the exact rate—the maximum rate—of the accommodation supplement for you.

Senator ALLMAN-PAYNE: Yes, I guess the maximum is probably what I'm particularly interested in.

Mr Shen: The current maximum rate is $70.94.

Senator ALLMAN-PAYNE: Thank you. The CEO of Uniting NSW.ACT is positing that that $70-a-day payment is around half the value of a RAD in a daily revenue to a provider. Is that right?

Ms Trainor: That would very much depend upon the room price for the room in question that the person is seeking to enter. Whilst I couldn't give you, off the top of my head, what kind of RAD a $70-a-day figure would equate to, there are a range of room prices in the system. Whilst, at the moment, for most of them the daily payment equivalent would be higher than that accommodation supplement rate, it's probably not accurate to say a non-supported person is worth this many dollars a day more than a supported person.

Senator ALLMAN-PAYNE: Yes, depending on the context.

Ms Trainor: Yes.

Senator ALLMAN-PAYNE: Okay. What is the average RAD at the moment?

Ms Trainor: Senator, what I can give you is the average agreed price that was reported in the *Financial report on the Australian aged care sector 2023-24*, and that average price was $451,000.

Senator ALLMAN-PAYNE: That was before the RAD cap was raised, though, wasn't it?

Ms Trainor: That's correct, yes.

Senator ALLMAN-PAYNE: And that went up—was it $200,000 or $250,000?

Ms Trainor: The cap increased by $200,000 on 1 January, and then it was indexed again on 1 July. The maximum is now $758,627.

Senator ALLMAN-PAYNE: So it would be fair say that it's quite possible that the average RAD has gone up now, if room rates have gone up?

Ms Trainor: It's certainly possible that the average price has gone up. We do know that more than 50 per cent of—and I've only got statistics for this on advertised prices, because of course an individual has the ability to negotiate the price downwards with their provider—

Senator ALLMAN-PAYNE: I'd love to meet the people who are able to do that. I haven't met any yet.

Ms Trainor: The statistics in front of me say that slightly more than 50 per cent of advertised room prices remain below that $550,000 price that was the maximum until the end of last year.

Senator ALLMAN-PAYNE: Is there anybody here who could tell me what the daily accommodation—no, that's not going to work. I'll keep going. It's late. I guess the concern that's being raised, and one that we share, is that it is very clear, based on the increasing prices of RADs and the daily rates that you're paying based on a RAD versus that maximum $70 supplement, that we're seeing a two-speed system develop. We're certainly hearing from people that people who don't have a RAD are finding it much harder, in many instances, to find places. Is it fair to say that if you don't have a RAD—for example, if you're a renter, and we're seeing more of those, or a lower-means entrant—a provider is financially incentivised to take the person who can pay a RAD because they're getting a higher rate?

Ms Trainor: It's certainly true that the provider has the ability to make the decision as to who they offer an available bed to and that there may be a range of factors that they take into consideration when making that decision. Mr Shen would be able to provide a little bit of information about the accommodation pricing review that the government recently announced and that will look at that accommodation supplement rate, if that's useful to you, Senator.

Senator ALLMAN-PAYNE: Yes, and maybe when that's due and whether we think there's going to be a significant increase that will narrow that equity gap.

Mr Shen: The report of the Residential Aged Care Accommodation Pricing Review is due to be tabled to parliament by no later than 1 July 2026. The review is being undertaken by two eminent persons, and that will be done independently. A decision to increase the supplement will be a decision for government. The review is, I would say, open for consultations right now, and we're hearing from a variety of stakeholders.

Ms S Stewart: Can I just make a comment.

Senator ALLMAN-PAYNE: Yes.

Ms S Stewart: I acknowledge your perception and observation about a—did you say a 'two-tier system'?

Senator ALLMAN-PAYNE: A two-speed system.

Ms S Stewart: I do want to acknowledge that perception. I do feel like it is important, though, to say that that is not the system that the government is investing in and that the department is seeking to run. We are seeking a system which puts older people at the heart of everything we do. We are seeking a system that is quality focused. We are seeking a system that is accessible. We're also reforming the whole journey so that people stay at home for longer in their family, in their kin and in their community and access the level of services. They can access doctors. They can access everything they need. For those who do need to go into care, they're able to.

We can see the investment, and, as the secretary has said, there's the residential deposit. There's also the higher everyday living fee in terms of improving that investability. There's also significant capital that got invested by government in a recent ACAT round. The last thing I would say is that we are very mindful and think very deeply about vulnerable Australians—the most vulnerable Australians accessing services. In the most recent ACAT

round, there was a homelessness service dealing particularly with men in a residential aged-care setting that was able to increase its capacity. I do acknowledge the perception and the concern about where this might go. That is not the intention of this system, and we are doing everything we can about that.

The other important thing to say is that, if the system isn't working as it should, one of the really key tenets of it is that people can make a complaint about things. There's a new complaints commissioner that was just announced today. I do acknowledge the perception. I do acknowledge the concern and the fear. I just want to assure you that that is not the system that the government is committing, and that is not the system that we are seeking to build. We keep it very much at heart in terms of how those that are more vulnerable in our community are able to access with dignity and care and choice.

Senator ALLMAN-PAYNE: I certainly understand what the government has articulated it is trying to achieve and what the department says the vision is. What I'm trying to highlight is that we are hearing from people that some people are being given preferential treatment to get into residential aged-care facilities because they have the means. At the moment, with the way the system is designed and because of the rate of that supplement, that is happening.

Ms S Stewart: Absolutely. We want to know about that.

Senator ALLMAN-PAYNE: Do you accept that, at the moment, that is happening?

Ms S Stewart: I have a different view. So, if you're asking me if I accept that, I would say it's not my experience. I do acknowledge that I'm fairly new in this role. I do acknowledge that I have visited some services. I have tried to visit every state and territory. I have not gone everywhere. I do acknowledge that people put me in front of certain services and not others. However, when I go and talk to people about the percentage of people in those homes, which is their community, the percentage is quite high of people who would be considered more vulnerable. That is my perception at the moment, but I'm completely open and would like to hear and understand about others where people's experiences are not that way.

CHAIR: Deputy Chair, I'm conscious that we are due to go to a break in a few minutes. How much longer might you require?

Senator ALLMAN-PAYNE: No more than 10, definitely.

CHAIR: I'm conscious that the officials have been sitting for quite a long period of time.

Senator ALLMAN-PAYNE: If you want me to stop and go to the break—

CHAIR: We can come back in 15, and you can try and tie it up. We will break now. We'll continue on to finish off outcome 3.

Proceedings suspended from 20:59 to 21:14

CHAIR: We're continuing with outcome 3, on ageing and aged care. I'm going to go to Senator Ruston to finish off her block of questions.

Senator RUSTON: My final question is in relation to residential aged-care beds, in terms of the bed build. Mr Comley, you made the comment about the changes coming in on 1 November in terms of the RAD retention and the changes to the payment arrangements et cetera. With 802 new beds this year, we're talking about 10,600-a-year growth over the forwards in order for us to meet demand into the future. Are there any other government measures that you or the minister is aware of that will need to be enacted in order that this extraordinarily significant uplift in the number of new builds over the next few years can be met and to meet the projections that the secretary mentioned?

Mr Comley: I have just one comment in response to that question. The number of 800 was put forward. I'll check with the team, but I think that was actually the 2023-24 number. I think last year it ticked up to around 1,600 beds built. The soundings we have from the sector are that, within the next couple of years, it will be more like 4,000. I'm not saying it's closing the whole gap, but—

Senator RUSTON: No, I'm just wondering. Obviously, we need to wait and see how the sector responds to the changes. I'm certainly not hearing that there is any great confidence at the moment about putting a shovel in the ground. You're now saying that it was in 2023-24 that it was 802.

Mr Comley: Was it?

Ms Evans: No. It was in 2024-25 that it was the 800 additional places. Secretary, I think the number that you were referring to is some data that we've got around what is in the building and development pipeline in terms of beds we expect to come online over the next few years. The 2025-26 number is 1,700—1,600 rounded up to 1,700.

Senator RUSTON: So that might be the number the secretary is talking about.

Ms Evans: Yes. And then, in the year beyond that—

Senator RUSTON: So they're all under construction, but they're just not available yet.

Ms Evans: Yes. They're yet to be finalised in terms of construction. They're not sitting there in a nice building ready to be opened, but they're—

Senator RUSTON: No. But somebody has started putting—

Ms Evans: Yes, and they have building applications and approvals in place.

Senator RUSTON: How many of the 802 or the new, in-progress ones are being built with government ACCAP funding and how many of them have actually been undertaken by the private sector?

Ms Evans: I think Ms Milfull will speak to the ACCAP expenditure and the ACCAP funding. The secretary spoke to the 1,700 and also referenced the 4,000 expected beds in 2026-27. We don't have a breakdown at this point of how many of those are ACCAP funded projects, but that is something that we're looking to match, in terms of data, going forward.

Senator RUSTON: Given what Ms Evans has just said, I'm interested in the 802 new places that came on line 2024-25. Do you have an idea of how many of those were ACCAP funded and how many were privately funded?

Ms Milfull: At this point we don't have a connection between those two figures. We could certainly investigate that offline for you. But I'd probably say that, obviously, the government has continued to invest heavily in ACCAP, basically, since 2022. Now we've had $951 million invested, and that's supporting a total of 211 projects. Just for your information, once those projects are completed, they are expected to add more than a thousand beds to the system.

Senator RUSTON: That's great. We were very pleased to get that additional $300 million added as part of our deal.

Ms Harper: Senator Ruston, I have just one final comment on the 802. Another caveat that I know we referenced earlier in the data caveats is that that figure is preliminary. It does relate to 2024-25, but it's preliminary data and does need to go through those data warehouse validation checks that Mr Pugh referenced earlier as well.

Senator RUSTON: Sure, but it's not likely to be terribly wrong; is it?

Ms Harper: I couldn't speak to that, but I'm just making it very clear that those are preliminary figures, and we may see some movement.

Senator RUSTON: When you think you might be able to validate them?

Ms Harper: They will go through the standard processes. I understand that probably within the next couple of months we would be in the situation where they will be reported through standard processes.

Senator RUSTON: We might be able to get them by December. If we are able to, it would be good to understand how many of them were actually private sector investment, because the most important thing for us, clearly, is that there is bankability of this sector—that they are prepared to invest.

I don't know if the inspector-general is still around. It may not be for her to respond; maybe it's for the government or the department. The I-G did a progress report. I think it was delivered to government 1 June, and I notice the minister waited until the last possible day to release this on the 4 September. I'm just wondering have you actually met with the inspector-general to discuss the outcome of her report, Mr Comley or Ms Stewart?

Mr Comley: Yes. The inspector-general and I met. I'm just trying to think exactly when it was, but it was about three weeks ago.

Senator RUSTON: Was it specifically about the report?

Mr Comley: The report was mentioned. We talked about other things as well.

Senator RUSTON: It was mentioned.

Mr Comley: Yes.

Senator RUSTON: Maybe this is for you, minister: does the government intend to provide a response to the findings of the report from Ms Siegel-Brown?

Senator Green: First of all, I thank the inspector-general for the report. It's a really important piece of work, particularly as we start to implement our new reforms but, more importantly, to keep track of those recommendations from the royal commission. I will just check for you whether there's a statutory requirement to respond, but, of course, we're considering the report. Whether there is a formal response or not, we want to make

sure that we're committed to continuous quality improvement, and that will include considering the report of the inspector-general.

Senator RUSTON: Has the government in the past responded, for instance, to the report of the interim inspector-general? Did the government respond to that, Mr Comley or Ms Stewart? Was a government response provided?

Mr Maldon: I'm not aware that we've responded to the annual progress report, but we would report to specific reviews that are in train, once we do get a report, as part of a natural justice process.

Senator RUSTON: So in response to the actual report, which is the equivalent of the report that Ms Siegel-Brown provided to the government on 1 June—the one that was provided to the government by the interim inspector-general has not been responded to.

Senator Green: Is this the report from 4 September?

Senator RUSTON: No; that was the one that you released—

Senator Green: Apologies!

Senator RUSTON: It was given to you on 1 June. I would just be very interested, Minister, as to why the government chose not to respond to the report of the interim inspector-general, and I would be very interested to understand whether the government is intending to respond to this significant piece of work that Ms Siegel Brown delivered to the government in June. If so, when would we be seeing the response to that report? Would it be possible by December, which is when we are next back? Because I would be very interested to talk to the inspector-general about her views about the response the government has to her report.

Senator Green: I'll take that on notice for you.

Senator RUSTON: Today we have traversed the issues around home-care packages and the incredible blowout in the waiting times and the waitlist. Obviously, 83,000 packages now have to be released over the next nine months. In terms of the 30,000 packages that Senator Allman-Payne was speaking to you about, is there provision or is the government committed to the release of at least the 30,000 new packages in 2025-26?

Senator Green: I'll just wait until the officials come to the table about the delivery of the packages.

Mr Comley: Mr Pugh will answer, but we're in 2025-26, which is the period that—

Senator RUSTON: Sorry, 2026-27, my apologies. I'm doing as well as you with how many builds there are and when they were built.

CHAIR: Senator Ruston, could I get an indication of how much more time—

Senator RUSTON: One question.

CHAIR: One question, and then we can move.

Mr Pugh: As I said previously, the government allocated 300,000 new places over the next 10 years to 2034-35, so that is 30,000 per year.

Senator RUSTON: But if it's 2034-35, you've already missed 2024-25. You've missed 2025-26. Are these 83,000 packages included in that 300,000?

Mr Pugh: Yes.

Mr Comley: My understanding of the government is a policy commitment of 300,000 over the 10 years be required—

Senator RUSTON: Was the time period 2024-25 to 2034-35?

Mr Pugh: No, 2025-26 to—

Senator RUSTON: So 2025-26 to 2035-36, and 83,000 have been released this year. That means there are only 22,000 or 25,000 going to be released per year in the subsequent years.

Mr Pugh: I think it's the 10 years inclusive of this financial year, 2025-26.

Senator RUSTON: So the 83,000 are in the 300,000?

Mr Pugh: Yes.

Mr Comley: The original policy commitment was to reach 600,000 by that period. The government hasn't committed to the particular profile of the release of the packages upon the three—

Senator RUSTON: I heard you say that before. Finally, if you wanted to remove the waitlist and the wait times down to the one month, which is the aspirational target that we've seen in your literature, how many new packages would be required by the end of 2025-26 to be able to meet that demand?

Mr Pugh: I don't think we have that figure in front of us. We're more than happy to take that on notice, though.

Senator RUSTON: Fantastic, thank you.

CHAIR: Senator Allman-Payne.

Senator ALLMAN-PAYNE: OPAN reported this week that residents are being refused access to residential aged care because their needs are too complicated. They've said that that includes people with dementia, or even just people who are smokers or are overweight. In other words, providers are discriminating and choosing residents who are either cheaper or easier to look after. One example that OPAN provided was an individual who'd been rejected by 21 facilities. I'm interested to know what the department's response is. What are people meant to do in that situation when providers are refusing to take them?

Ms Garrett: We are aware that that does sometimes occur. I guess one of the things that is important is that providers are able to make decisions around the people that they take on, based on the type of care that that person needs. They're trying to do an important piece, which is about matching their available services to that person's needs. It is one of those issues that has been reported before—OPAN have raised it before. It is certainly something that we don't think is good or should continue. We continue to try to work towards that not being the case.

Senator ALLMAN-PAYNE: Is there tracking of aged-care refusals?

Ms Garrett: No.

Senator ALLMAN-PAYNE: Is there a mechanism for determining how often aged-care service providers are refusing care to people?

Ms Garrett: No, there isn't any tracking like that.

Senator ALLMAN-PAYNE: Is the department doing any work in relation to this issue to try and prevent it?

Ms Garrett: Not specifically, but there is a range of programs that are underway that are attempting to uplift the capability of providers to look after a wide range of people, and people with different clinical needs or different behavioural needs. Those programs are in place now and will continue. I do know that the commission also has programs that look at supporting providers in some of those higher needs or more complex scenarios.

Ms S Stewart: The other really important thing with the commission is the complaints commissioner. If individuals are feeling that there are decisions that are—they can complain about a whole range of things. But that would also be a source of opportunity to track that, in terms of individuals coming forward with those concerns. And I should say that we do thank OPAN for their report. They're a really important stakeholder and advocate on behalf of older people and the good relationship that we have with them.

Senator ALLMAN-PAYNE: Is this a sign that a profit-driven care system is failing people? I'm trying to imagine an instance, for example, where a public hospital would refuse someone because their level of need was too high.

Ms S Stewart: I think I would refer to the comments that I was making previously about choice, dignity, care, quality and respect. That is a system that we are building with the safeguards that are necessary in that. I would refer to my previous response around that.

Senator ALLMAN-PAYNE: Could I maybe put a couple of questions to the inspector-general. Thanks, Ms Siegel-Brown. I'm just wanting to come back to a couple of the issues that I raised earlier. One is in relation to this question of people who can't pay a RAD—at the moment, a maximum of $70 is the supported payment—and our being told that people are experiencing difficulty accessing residential aged care if they're less financially appealing to a service provider. Similarly, there is this issue of people who are considered too complex or have higher needs and aged-care providers being able to pick and choose, essentially, who they're taking. I'm wondering what your view is on how that fits in with the aged-care royal commission recommendation that we need to be providing care to everyone who needs it, in the context, too, of a system that needs to be demand driven and where everyone has access to care.

Ms Siegel-Brown: I would say to you that a lot of the concerns you've just reflected are concerns I've heard throughout my consultations. Probably more loudly than the one about whether people are being refused service on the basis of how wealthy they are, we have heard about people being refused service on the basis of their complexity, and that might sometimes be when somebody is being released from hospital into aged care and their behaviours are more complex than an aged-care provider is, perhaps, prepared to take on. We're not hearing it across the board, but we certainly are hearing it happen.

First of all, you asked about the royal commission and whether I think that this practice, even if it's a tacit practice and not an intended practice, is in line with the royal commission. It is absolutely fair to say it's contra to the royal commission's intention. There are very explicit recommendations right throughout the royal commission about equity, mitigating vulnerability and the entitlement of all people to care that is rights based and person centred. As I discussed earlier, I also acknowledge that there is a finite budget with growing demand. But I would say to you that my view is that, while we may not be able to just find endless buckets of money to service everybody in aged care—albeit I really, truly wish we could—the fact is we might be able to think about the incentives and disincentives within the system that are creating these behaviours from certain providers. And that's really the tenor of my report.

We have set a really noble compass, but there's still a distance between the compass and where the system is now, and we do need to think about how we've geared the incentives and disincentives around certain behaviours. While we do reforms in perhaps isolated pockets, we may be creating some unintended consequences, and you've just demonstrated one of those.

Senator ALLMAN-PAYNE: Are those things that you will be tracking in terms of then measuring them against the royal commission and its recommendations? Are those things that are on your radar?

Ms Siegel-Brown: Yes, absolutely. As part of the consultations that we did on the progress report on the royal commission, the key question we asked people was, 'We've got this vision that's been set by the royal commission, and we've got 148 reforms that we've kind of treated as equal to each other, but we haven't necessarily sat down and said, "What's the theory of change here that's actually going to deliver on that vision? How should we sequence some of these reforms et cetera?"' And so we were asking people, 'What would be the most transformational ones to revolutionise the system?' Based on that, we've developed our work plan for the current financial year. In fact, I recall that in the meeting Mr Comley referred to, that was very much the subject. There were the issues that we isolated as key from our consultations. They are therefore the things that we are going to not just review but monitor. So some of the things that you've just mentioned will absolutely fall into our monitoring work over next financial year and may result in a review going forward, including, of course, the single assessment system which was recommended by the earlier inquiry.

Senator ALLMAN-PAYNE: Thank you. I'll leave it there.

CHAIR: Senator Ananda-Rajah.

Senator ANANDA-RAJAH: I'm interested in the Aged Care Capital Assistance Program. Obviously we're interested as a government in building more aged-care beds now not just into the future. We've heard a lot of discussion about possible predictions around demand into the future, but I'm interested to know what we're doing now through this program and how our current grant round compares to previous grant rounds.

Ms Milfull: For the current round, we just recently announced our competitive round, referred to as 'round 3', and that made $300 million available to fund 66 infrastructure projects. That was the largest round to date—the one before that was $250 million—and I believe, in terms of a single round, that it's a record investment. Basically, as a result of that round, we hope at least an additional 315 beds would be created once those projects are finished. Importantly, too, this round ensures that there's $87 million going towards 12 projects to specifically support Aboriginal and Torres Strait Islander people, to improve access to culturally safe services. That's a great outcome.

Senator ANANDA-RAJAH: It is.

Ms Milfull: I'll pull out one other specific one, which was a record investment of $51 million as part of this round in a new 94-bed residential care home in Broken Hill to ensure service continuity. I believe that's the largest individual ACCAP grant that we've ever had.

Senator ANANDA-RAJAH: That's fantastic. We've got a list here of all the grants around the country. There are quite a few in Victoria, but they are dispersed all around the nation by the looks of it.

Ms Milfull: That's right. They're all around the nation, with different percentages, which we look at. Basically, we have an assessment committee that considers all the applications and takes into account the greatest need when we're recommending to the delegate which projects to actually support.

Senator ANANDA-RAJAH: Are there any innovations with respect to design of these homes and facilities that might be more tailored to the needs of older people and maybe even be co-designed with them?

Ms Milfull: Certainly, as part of the grant guidelines for ACCAP, we basically expect now that providers would put forward designs that are consistent with the recent design principles. We want to encourage that dementia-friendly homelike environment and that sort of small scale infrastructure that we believe is preferrable

moving forward. These things take time, obviously, but we'll keep monitoring how ACCAP is delivering in that space. But it's certainly one of the reasons that we've prioritised applications that deliver particularly that homelike environment.

Senator ANANDA-RAJAH: Do the grant guidelines preference dementia-specific design, or do they incentivise that?

Ms Milfull: They have to be taken into account if not be essential at this point, noting that they're still principles. I think the key thing you'd find that we prioritise are applications that really improve access to services in thin markets. We're also interested in improving access to quality care, and that would include that dementia element. The other important part of ACAT, moving forward, is that we also deliver funding to support the building of staff accommodation where we have applications that provide for that. And that will help address some of the staffing challenges that we've been discussing throughout the evening.

Senator ANANDA-RAJAH: Is that particularly in regional and remote areas?

Ms Milfull: Yes. ACAT, generally speaking, is focused on non-metropolitan areas. It's a thin market focus, which is generally regional and remote, but it can be also be, for example, our specialist Aboriginal and Torres Strait islander and, as the deputy secretary mentioned earlier, homeless services is another category where, even if in a metropolitan area, we would consider it a thin market, and, therefore, that would be a worthy project.

Senator ANANDA-RAJAH: So projects in a metropolitan area that serve a particularly vulnerable or under-served group, like homeless Australians. I understand there was a project in Perth. Can you tell us about that one?

Ms Milfull: That's right. I think it was the day before we announced round 3, the minister also announced that we've invested a further separate $30 million, and this will build a new 80-bed home in east Perth, with the provider St Barts that specialises in the delivery of specialised home-care services to homeless people. This project is designed to ensure they can include, in particular, older women with a history of homelessness. So, yes, St Bart's will contribute a further $16 million to the project. It's a partnership, and it will ensure there are 80 rooms available across seven levels with dedicated floors for male and female residents as well as some culturally inclusive common areas. It's a good example of a place where ACAT has been used in a metropolitan region of Perth, contributing more beds in that area which are much needed, because it's still considered a thin market, if that makes sense.

Senator ANANDA-RAJAH: I don't have any further questions, Chair.

CHAIR: Thank you. Senator Steele-John.

Senator STEELE-JOHN: My questions will be to IHACPA in relation to the report written by the authority on NDIS pricing.

Mr Comley: Chair, can I just check—and this may have been pre-arranged—disability is tomorrow. Is it just that IHACPA is coming just this evening and not tomorrow with the rest of the disability outcome?

Senator STEELE-JOHN: That's my understanding.

CHAIR: Just for clarification, I haven't pre-arranged, so I am listening very carefully to the content of the question and where it falls into. I don't know the content of the question. I just want to put it on the record that I am listening carefully and will be guided by the officials about whether we can answer this question here, or if it is possible for tomorrow. We can work through that, whether it is in the relevant place.

Mr Comley: To be clear, it would be more efficient for Professor Pervan to be here tonight rather than tomorrow for this thing. I can see the logic of that. I'm sure he won't mind.

CHAIR: Senator Steele-John.

Senator STEELE-JOHN: Can I confirm the date that IHACPA provided the report to the minister.

Prof. Pervan: You're going to have to let me check on that. It was late last year, and I wasn't actually a question on this tonight. I can't remember the exact date, but it was in November last year.

Senator STEELE-JOHN: If you could take on notice the precise date, that would be fabulous. Thank you.

Prof. Pervan: I'm happy to do that. Did the report contain recommendations for cabinet?

Prof. Pervan: Yes.

Senator STEELE-JOHN: Has there been any further consultation by the minister with the authority on the matter of NDIS pricing since the report was provided to the minister?

Prof. Pervan: We received written notification that he'd received the report and was considering it late last year.

Senator STEELE-JOHN: Could you give me that date on notice as well?

Prof. Pervan: Certainly.

Senator STEELE-JOHN: The report stated:

The number one concern raised was how **pricing doesn't reflect the reality of delivering services, especially in remote areas and for people with complex disabilities.**

My understanding of this understanding is that pricing is often too low for therapy supports provided in remote areas and for people with complex disabilities. Is that correct?

I'm not trying to be evasive, but the nature of the report was that it was a report prepared on request from the minister under our legislation. It is, in fact, his report and not mine. At this point, I'm unsure of what the protocol is as to what I can or can't discuss in it given that the report has not been accepted or approved by government. I don't know if it's even been presented to cabinet. As far as I know, the minister is still considering it. It's a report for the minister and it belongs to the minister. I'd have to take advice as to the extent to which I can even answer the question.

Senator STEELE-JOHN: Can I clarify for you? I do know that you're unable to go into detail about the recommendations of the report. I'm quoting from the publicly available section of the report, which we heard. I'm confining my questions to that in this line, so I'll just try again. The quote from what we heard piece is:

The number one concern raised was how **pricing doesn't reflect the reality of delivering services, especially in remote areas and for people with complex disabilities.**

My understanding of this finding is that pricing is often too low for therapy supports provided in remote areas for people with complex disabilities. Is that correct?

Prof. Pervan: That's my understanding of the feedback we received during consultations, yes.

Senator STEELE-JOHN: Thank you. The report also states that pricing is impacting on the safety and quality of support, particularly partly because there often aren't funds available to invest in staff training. Can I please clarify again that this is because prices are too low?

Prof. Pervan: That's the feedback that we had during the community consultations. As you've pointed out, the title of the report is *What we heard report*, and you've just repeated some of what we heard. The responses and feedback that we had during community consultation didn't go into a stage of validation with NDIA and other organisations; this is literally just the feedback document from all those people who contributed during the consultation that we undertook.

Senator STEELE-JOHN: Thank you. As I said, I am aware that that you're unable to provide the report in full or in part or to go into detail about the recommendations of the report since the minister has said that it is cabinet-in-confidence, but, based on what you've published publicly and what was heard in the consultation, is it fair to say that the NDIA making the decision to lower prices for some therapy supports and reducing the travel allowance isn't really aligned with what the report found?

Prof. Pervan: Yes, I think I could say that it's not aligned with the feedback that we had from the communities.

Senator STEELE-JOHN: Thank you. One last question: you very proudly, on the second page of the report, talk about the extent of consultation with the community. Some 750 people were engaged across Australia, some 35 in person in online workshops and some 445-plus submissions. What was the total cost to the authority for doing this consultation work and the report overall?

Prof. Pervan: I'm afraid I will have to take that question on notice as well.

Senator STEELE-JOHN: Thank you very much, Professor. Minister, given that the agency's decision to reduce pricing for certain therapies and supports, everything from OT to dieticians, and the decision to reduce the travel allowance isn't really aligned with what it sounds like this report found, is that why the government is insisting that there is cabinet in confidence around this report's recommendations? It actually very clearly says to you that you shouldn't—well, I should reframe, since it is an independent agency. Isn't that really why the government hasn't instructed or asked the agency to re-think its decisions around pricing and at least been clear with the community and released this document?

Senator Green: Senator, you know that this is a question for the minister tomorrow. I'm not quite sure why you're attempting to put it to me. In any event, I can take it on notice, but you will have the minister in front of you tomorrow where you can ask her and get a fulsome answer.

Senator STEELE-JOHN: I'll be taking that opportunity fulsomely tomorrow.

Senator Green: I'm not sure why you're asking me that question now.

Senator STEELE-JOHN: You never know your luck.

Senator Green: There is an order to these things, Senator.

Senator STEELE-JOHN: There absolutely is.

Senator Green: I just wouldn't want you to insinuate that I didn't want to answer your question or not appear to have the answer because you are perhaps deliberately putting the question to the wrong minister.

Senator STEELE-JOHN: No, I most certainly wasn't doing that, as a part of a government that's claiming cabinet in confidence over a document—

Senator Green: No, this is it again, Chair.

Senator STEELE-JOHN: that the public has the right to see.

Senator Green: We're going through a topic which is quite clearly up for discussion tomorrow.

Senator STEELE-JOHN: I think we'll leave it there, and then we'll continue to pursue this in the chamber as well.

Senator Green: Sure.

CHAIR: Senator Steele-John, in the interest of time—

Senator STEELE-JOHN: We're sorted.

CHAIR: Thank you. We have now concluded outcome 3, Ageing and aged care. We're happy to release from the program the Aged Care Quality Safety Commission, the Independent Health and Aged Care Pricing Authority and the Office of the Inspector-General of Aged Care. We are now moving to outcome 2.

Department of Health, Disability and Ageing

Australian Digital Health Agency

[21:54]

CHAIR: Welcome to our officials from the Department of Health, Disability and Ageing for outcome 2, Individual health benefits, and the Australian Digital Health Agency as well. I'll go to Senator Ruston for questions.

Senator RUSTON: As we discussed this morning, I said I was going to ask bulk-billing questions tonight. On the government's stronger Medicare website, it highlights that not all GPs bulk-bill all patients and that, if the GP doesn't bulk-bill, patients will need to pay. Will this advice remain valid after 1 November?

Mr McCabe: Can you please repeat the question?

Senator RUSTON: On the department's website, it says that not all GPs bulk-bill all patients and that, if the GP doesn't bulk-bill, patients will need to pay. I'm keen to understand whether that will be updated on 1 November.

Ms Shakespeare: I don't think that, from 1 November, bulk-billing will be mandated for every patient.

Senator RUSTON: Oh, okay. So you will need more than just your little green Medicare card when you go to see the doctor, perhaps?

Ms Shakespeare: There will be bulk-billing incentives available from 1 November. As I think was discussed earlier in the hearings, there will be a program commencing from 1 November providing practices with incentives, quarterly and arrears, that we expect will grow over time.

Senator RUSTON: So it's not going to be free for everyone to go and see the doctor as of 1 November.

Senator Green: That's not what we—

Senator RUSTON: I think you might find that the Prime Minister said, 'All you'll need when you see the doctor is your Medicare card,' and, 'Seeing your GP will be free.'

Senator Green: Senator, you made the same commitment. What we committed to was that, on 1 November—

Senator RUSTON: No.

Senator Green: Oh! I thought you did? I thought it was a bipartisan—

CHAIR: Senators, I know it's getting late in the evening—

Senator RUSTON: We want to see all Australians bulk-billed, Minister.

Senator Green: That wasn't your policy either. To be clear, on 1 November, our increase to bulk-billing incentives will commence, and what we've committed to is for that to increase until 2030. I don't know why

you're insinuating that automatically, on one day, the commitment we made that goes until 2030 will be in place. That's now what we committed to, and it's not what you committed to at the election either.

Senator RUSTON: But your prime minister did say: 'All you need to see a doctor under Labor is your Medicare card. Seeing your GP will be free.'

Senator Green: Because we're increasing bulk-billing incentives.

Senator RUSTON: Is it going to be free?

Senator Green: Till 2030—that's our policy. It's the same policy that you committed to at the election.

Senator RUSTON: Will it be free in 2030?

Senator Green: It's the same policy you committed to, I thought. Maybe I'm wrong.

Senator RUSTON: Senator, you're being tricky.

Senator Green: I'm not being tricky!

Senator RUSTON: Your prime minister lied to Australians.

Senator Green: Oh, my goodness, Senator.

Senator RUSTON: Does the department collect data on the number of people that are bulk-billed, as opposed to the number of services that are bulk-billed?

Ms Shakespeare: Yes.

Mr McCabe: Yes, we do.

Senator RUSTON: Is that publicly available?

Mr McCabe: I'd have to check what we have in our quarterly statistics. We do talk about numbers of people that were bulk-billed 100 per cent of the time. I don't know if we'd call that the actual number of people, but it is data we do have.

Senator RUSTON: I'm interested in seeing the data because we often hear about the number of services that are bulk-billed. I'm interested to understand how many people are bulk-billed—so how many times, if you present to a GP, you are fully bulk-billed. If we could get that information, that would be great. Based on the most recent Medicare data that you have, what is currently the average out-of-pocket cost for a GP attendance?

Ms Shakespeare: Level B GP attendance? There are different GP attendances.

Senator RUSTON: There's obviously going to be one for the whole lot. You can give me level B, given that's the most common consult.

Mr McCabe: At the end of 2024-25, the average patient contribution per service for general practice was $49.14.

Mr Comley: I'm sure you know this, but, just in case others are watching, that's if you're billed. Obviously, the average is lower when you take in the bulk-billed.

Ms Shakespeare: And the majority of services are bulk-billed and do not have a cost at all.

Senator RUSTON: But the average out-of-pocket cost when you see your GP is $49.14.

Mr Comley: If you face an out-of-pocket expense.

Senator RUSTON: Exactly, but we don't know how many people face an out-of-pocket expense because we're waiting for Mr McCabe to get me that data. When does the department envisage that that out-of-pocket cost will be down to zero?

Mr McCabe: We probably need to explain the way this average is calculated. In fact, it will probably go up as more people are bulk-billed, because we will have outlier GPs that are charging higher out-of-pocket expenses, and, if they continue to do that, the average for that subset of patients will be higher for a period of time.

Senator RUSTON: In relation to this 2023 timeframe that has been put in place for the bulk-billing rate to be at 90 per cent, not free, we are sitting at the moment at about 77.8 per cent—is that correct?

Mr McCabe: I think the number at the end of last financial year was 77.9 per cent for the whole of last financial year.

Senator RUSTON: What is it at the moment? Do we know what it is today?

Mr McCabe: I'll see if I've got it handy or check with my colleagues.

Ms Shakespeare: We try and provide statistics on a consistent basis, which is over the course of the year rather than a month.

Senator RUSTON: That's absolutely fine. Are the measures that have been proposed to be put in place to get the bulk-billing rate to 90 per cent, which were announced as part of the package that was announced in an election campaign and which are due to come into effect on 1 November, predicted to get the bulk-billing back up to 90 per cent by 2030? Is that the premise here?

Mr McCabe: Yes.

Senator RUSTON: So they come into effect on 1 November?

Mr McCabe: That's right.

Senator RUSTON: Why are you expecting it to take from 1 November 2025 to 2030 for these measures to have an impact? Why wouldn't you expect them to be taken up more quickly than that?

Mr McCabe: When we modelled this significant investment, we looked at what happened historically in Medicare when governments made interventions around bulk-billing. We had a similar issue with bulk-billing back in the early 2000s, when the then Howard government had to make a significant set of measures to try and increase bulk-billing. It took four years for GPs and GP practices to take on board all those measures and roll them through. So we expect that kind of behaviour will occur in this instance as well.

Senator RUSTON: We're sitting here at 77.9 per cent for the rolling average, and you're talking about 90 per cent in 2030. Clearly, in the modelling of that you must have some sort of trajectory. Can you give us the modelled figures for what the bulk-billing rate will be on 30 June 2026, 2027, 2028, 2029 and 2030.

Mr McCabe: The way the program has been modelled, the key objectives for the program actually don't talk about bulk-billing increases in those kinds of periods. All we actually looked at is what we expect to occur in terms of the number of practices that would enrol in our bulk-billing program. As I said earlier, there are 4,800.

Senator RUSTON: I'll come to those in a minute.

Mr McCabe: Of those, 3,600 are expected to occur in the next two years.

Senator RUSTON: You have a bulk-billing rate of 90 per cent in 2030. There has got to be trajectory from here to there. What is it?

Ms Shakespeare: At page 25 of the impact analysis that was prepared to support consideration of this measure, we have objectives, success factors, and metrics and targets. That was what inform the government's decisions around these measures.

Senator RUSTON: Are they available?

Ms Shakespeare: It is published on the Department of the Prime Minister and Cabinet's website.

Senator RUSTON: Could you tell me, then, if they're published and you've got them in front of you, Ms Shakespeare, what is the bulk-billing rate anticipated to be in 2026, 2027, 2028 and 2029?

Ms Shakespeare: It didn't have that each year. Eighty-seven point eight per cent of GP NRA services would be bulk-billed by the 2028-29 financial year, and 3,600 GP practices would sign up to the clinics program over the first two years of the measure. We had other targets in there as well.

Senator RUSTON: But you don't have any targets—

Ms Shakespeare: That's part of the impact analysis prepared and published for this measure.

Senator RUSTON: So you're telling me that you don't have any bulk-billing targets until after the next election?

Ms Shakespeare: This was what was prepared in the impact analysis to inform government's consideration of the proposal.

Senator RUSTON: From what I understand there, you do have the number of fully bulk-billed practices that you are expecting over the forthcoming years. Do you have those figures for 2026, 2027, 2028 and 2029?

Ms Shakespeare: The success metric target in the published impact analysis is 3,600 GP practices sign up to the clinics program over the first two years.

Senator RUSTON: Behind those metrics obviously a whole heap of work has been done. Is there any further more granular detail in relation to the bulk-billing rates and the number of GP practices that will sign up to the bulk-billing incentive year by year? Clearly, something has informed those metrics. Is there any more information you can provide that hasn't been published so that we can understand what we're measuring against? When we get to June next year or November next year or whenever those measures come into play, how can we measure whether this has been successful and delivered on it if we've just got these random metrics that are not provided

for all of the years? Is there any more information behind this? How did you get those metrics? Or did you just pick them out of the air?

Ms Shakespeare: No. There was a lot of modelling using data that we receive through the administration of the Medicare Benefit Schedule, which is protected by provisions in the Health Insurance Act, which means we have to be quite careful about what we publish and making sure that we don't identify data from that. There hasn't been a lot of the actual model data released, because it is protected under the Health Insurance Act. But, to the extent that we have published information about that modelling, that is set out in the impact analysis that was published on the Department of the Prime Minister and Cabinet's website for this measure. We've also provided tools and facilities for practices to look at their own data and use a calculator to look at how the policies would impact on them.

Senator RUSTON: How would publishing an annual target for bulk-billing rates impact on the private Health Insurance Act?

Ms Shakespeare: I didn't say that it would. These are the measures that have been published, but—

Senator RUSTON: I'm trying to understand why you're not publishing the statistics before 2028-29?

Mr McCabe: As I explained before, over the forward estimates, as we've seen historically, that is the time required for these significant investments to wash through and have the impact that we're expecting. How that occurs is really something that we don't have direct control over. The government is putting investment into this space, but we are working with every practice and GPs to get them to take this up at their—

Senator RUSTON: I get that. I just don't understand why, if you've done the modelling to come up with these figures, you can't give me more granular detail on it. I would contest, Ms Shakespeare, that the information I'm asking for is not going to be in any way breaching the Private Health Insurance Act. In terms of the 12½ per cent fully bulk-billed practice incentive that is being proposed, if a practice charges a co-payment for a procedure that is not covered, such as a skin check or an iron infusion or something like that, are they still eligible to be a practice if it's fully 100 per cent bulk-billed?

Mr McCabe: Yes. The program was designed around consultation services, which is the majority of services that GP practices do for patients.

Senator RUSTON: So a patient who goes into a clinic actually technically won't be fully bulk-billed for the purposes of the fully bulk-billed incentive. So I could go into a practice that says, 'I'm 100 per cent fully bulk-billed,' and they'll be getting the 12½ per cent, and yet I still quite reasonably cop the co-pay for some things.

Mr McCabe: In the examples you gave for GPs doing procedural services, that's correct, but we will require under the program to make that very clear for those practices that are offering specialised services like skin checks—well, not so much skin checks but skin procedures.

Senator RUSTON: I think you answered this to Senator Pocock this morning around the ACT, but you've obviously got a registration for information out at the moment. How many practices have expressed an interest in being fully bulk-billed so far?

Mr Roddam: Is this for the ACT specifically?

Senator RUSTON: No, the ACT-specific clinics are another story altogether. You've got a registration out at the moment for GP practices who would like to consider to move to the 100 per cent bulk-billing for the 12½ per cent BBPIP payment. How many clinics have so far registered an interest?

Mr Roddam: An expression-of-interest process—

Senator RUSTON: No, not in the expression-of-interest process—registered an expression of interest. You can ask for information about it, but how many have actually expressed an interest in wanting to join?

Mr Roddam: Yes, that's the process. An expression-of-interest process has recently opened, but Ms Da Rocha will give you that figure.

Ms Da Rocha: As of this morning, the latest figures are over 900 practices have expressed an interest in the program.

Senator RUSTON: How many practices currently are 100 per cent bulk-billed by the description of 100 per cent bulk-billing that we're talking about now?

Ms Da Rocha: I think my colleagues can help you out with the number of current practices, but if we're expecting to triple the bulk—

Senator RUSTON: No, I'm asking what's actually happening now, not what we're expecting.

Mr McCabe: When we did the modelling for this measure, there were between 800 and 850 practices that did 100 per cent bulk-billing.

Senator RUSTON: Have you got any correlation between the 800 or so and the 900 you've got as to whether they're the same ones or different ones?

Mr Roddam: We haven't undertaken that analysis.

Senator RUSTON: So it could quite reasonably be that the current bulk-billing clinics are the ones that are expressing the interest in the part payment. At the Press Club recently, the Prime Minister said:

We, in last year's Budget, tripled the bulk billing incentive for concession card holders. And what that has done is lift bulk billing rates up to well above 90%.

In May 2022, the bulk-billing rate for under-16s was 94.3 per cent. That was under us. If it was 94.3 per cent, how is it that we are crowing about lifting it back over 90 per cent when it was already 94.3 per cent?

Mr McCabe: There are probably a couple of things on that. The bulk-billing rates coming out of the COVID pandemic across the board, across all parts of the population, were very high. In the 2021-22 financial year, there was at least a 1.5 per cent increase in bulk-billing because we had mandatory requirements for bulk-billing COVID vaccination assessments. Those assessments and the GPs' use of those items fell away very quickly in the following financial year.

Senator RUSTON: What was the bulk-billing rate for this cohort in 2019?

Mr McCabe: I don't have that with me.

Senator RUSTON: Maybe you should look it up. Could I just ask—

Senator Green: It doesn't matter if the college of GPs called the figures that you use 'misleading' and 'significantly skewed'?

Senator RUSTON: I've just asked a question about the 2019 figures.

Senator Green: Yes, that's about the figures that you're talking about, about bulk-billing going up—

Senator RUSTON: In 2019.

Senator Green: or being higher in 2022 or just before 2022.

Senator RUSTON: If you have a look at the figures in 2019, you will also see that they were significantly higher than they are now.

Senator Green: I'm talking about the figures you used just before the 2022 election—

Senator RUSTON: So you don't know the figures in 2019?

Senator Green: The college of GPs called them out, describing them as 'misleading' and 'significantly skewed'.

Senator RUSTON: And the 2019—

Senator Green: The college of general practitioners said that, under your government, bulk-billing was in free fall.

Senator RUSTON: No; you said that. In terms of private health insurance, since we're talking about that, it says, 'Labor sends unprecedented warning to health insurers,' and then it goes on to quote that the minister had written to private health insurers. I'm wondering: is it possible to get a copy of that letter?

Mr Comley: Can I just check, Chair, whether we're moving on from bulk-billing to private health insurance?

Senator RUSTON: Yes, sorry. Ms Shakespeare loves the Private Health Insurance Act!

Mr Comley: It's just that it's different people.

Senator Green: It is different officials.

CHAIR: I am just checking how much time you need—

Senator RUSTON: That was my only question—can we get a copy of the letter?

CHAIR: To clarify, which letter?

Senator RUSTON: It was a letter that described Labor sending an unprecedented warning to health insurers—

Mr Comley: We've already provided it.

Senator RUSTON: You have?

Mr Comley: Yes. It was in your request, and it was provided in the package materials this morning.

Senator RUSTON: I didn't see it.

Ms Street: It was in the statement-of-expectations document.

Senator RUSTON: No—yes. Was that in there? I didn't see it. I went through the pack.

Mr Comley: We'll double-check, if you want, with your office—or actually with the committee because we tabled it with the committee—but my understanding is that we provided that.

Senator RUSTON: That's fine. I just wanted a copy of it because it wasn't there.

CHAIR: If it has been requested from the department, and if it can come via the committee to be tabled—I think that is the request—I am happy for that to happen.

Mr Comley: Perhaps we can check with the secretariat whether they have it, and, if not, we will re-provide it.

CHAIR: I'm getting a no from the secretariat at this point, but we will check.

Senator RUSTON: There was another thing in the documents that you provided me this morning, Mr Comley. You said, 'It was not possible in the time available to provide a status update on each of the reviews.' Can I read that as, 'You will provide me with a status of the reviews, but you just haven't been able to do it yet'?

Mr Comley: We will take it on notice. Yes. There are 70 reviews. As you can imagine, it's not quite a done/not-done type of response. So we'll take that on notice.

Senator RUSTON: But there are some pretty significant reviews in that process. During the 2022 election campaign, the Prime Minister posed with a baby who had Pompe disease to launch Labor's end to the postcode lottery in terms of screening for 80 conditions nationally, including Pompe disease. Is it still the intention, Minister, for the government to screen newborn babies and make available the screening of Pompe diseases?

Dr Develin: Good evening—

Senator RUSTON: Sorry, that is just to the minister.

Senator Green: The official has got the answer for you. I'm going to seek some advice for you. We're switching around from different topics, so give me a moment, but the official has the answer.

Dr Develin: Good evening. As you're aware, the program is a collaborative initiative between the states and territories and the Commonwealth, as they run the screening programs. Part of the decision-making framework includes that MSAC will provide ministers with advice on their position on conditions that should be in the screening program. Once MSAC has made its recommendation, that then goes to all health ministers to make the decision on whether that will be added to Australia's newborn screening programs. At this stage, MSAC's recommendation was that Pompe should not be included, and that advice will soon be going to ministers for their decision.

Senator RUSTON: Minister, has the Prime Minister got any intention of apologising to the mother of that child and the mothers of other children in Australia that have Pompe disease, when he promised in 2022 that he was going to end the postcode lottery, holding this baby? Now, through a process of the department, MSAC have made a recommendation. I'm interested to understand whether the government is intending to keep its promise and overturn—or not accept—the MSAC determination. Or is the government going to walk away from its commitment in relation to Pompe disease?

Senator Green: We are going to deliver on our commitment. This is the first time, I think, that MSAC has not supported the screening of an NBS condition. The process that Dr Develin has walked you through still requires the minister to make some considerations on that.

Senator RUSTON: Do you have any idea when the minister is likely to make those considerations?

Senator Green: I can take that on notice for you.

Senator RUSTON: It was a specific commitment to the parent of a child with Pompe disease. There was an announcement of $38.4 million over four years in the 2022-23 budget. Since then, how many additional conditions have been added to the newborn bloodspot screening program and are intentionally screened for in every state and territory today?

Dr Develin: I'll answer your second question first, and I'll see if my colleague has the progress. There are 37 target conditions that are included—which is, as you say, intentional screening.

Senator RUSTON: Is that intentional screening in every state and territory?

Ms Hermann: Could I just clarify. There are 37 target conditions, five of which are currently under implementation. So there are 32 target conditions that are screened consistently across Australia.

Senator RUSTON: In the last two estimates in which I've asked about this it's been 32. When was the last time we actually finalised the adding of an intentionally screened disease in every state and territory?

Ms Hermann: We can take that on notice.

Senator RUSTON: Okay. As of today, there still only 32 conditions that are intentionally screened in every state and territory?

Ms Hermann: Target conditions? Yes.

Senator RUSTON: Minister, that's a significant discrepancy from the commitment of 80. I'm interested in whether the government is moving away from its commitment, or is the government still committed to the delivery of all 80?

Senator Green: We're still committed to the commitment we made.

Senator RUSTON: You've only got one year left to do it in.

Dr Develin: Senator, I'm happy to provide additional detail about the notion of the 80, because that is quite often referred to, and I appreciate that.

Senator RUSTON: It's only quite often referred to, Dr Develin, because that's what the Prime Minister made a commitment to in the 2022 election. I'm quite well aware of the many times that you've explained to me why that was never possible, but the Prime Minister still made the commitment, and most particularly around—

Senator Green: I don't think it's about being possible; I think it's about the classification of conditions. Am I right, Dr Develin?

Senator RUSTON: Yes. Dr Develin and I have done this back and forth a lot, so I certainly understand the situation. I'm just trying to understand—a commitment of 80 was made, and it appears that a commitment of 80 could never have been delivered in the context of how it was promised.

Senator Green: We're just using different terms.

Mr Comley: I do think, though, for the record—and Dr Develin would comment—the 80 and the 32 or 37 are not like for like, because the 80 conditions in the US have non-target commissions as well.

Senator RUSTON: We know. That's fine—I look forward to hearing what the minister's determination is in relation to the MSAC decision and Pompe disease. Is there anybody here who could answer a few questions about the PBS and tariff negotiations?

Mr Comley: We're happy to take questions when you're ready. We've got the right people. Obviously, tariff negotiations are a matter for DFAT, not this portfolio.

Senator RUSTON: Did the department of health provide any input into the Australian government's submission to the US government in relation to their—I think it was section 232—national security investigation of imposts on pharmaceuticals?

Mr McIntyre: The department was consulted by DFAT, and we provided our advice to DFAT, who were responsible for that. They would be able to answer more detailed questions about that sufficiently.

Senator RUSTON: It was just DFAT that asked you for the input into the submission.

Mr McIntyre: DFAT were responsible for the Australian government's submission. It was their responsibility to ensure that they could have the right advice to underpin that submission.

Senator RUSTON: Has the department provided any input into the briefing materials for the Prime Minister's up-and-coming visit to the US president on pharmaceuticals or on the potential impact on Australian exporters?

Mr McIntyre: It's, once again, the responsibility of the Department of the Prime Minister and Cabinet—and, in this instance, supported by DFAT—to brief the Prime Minister on such visits. The department of health is consulted on issues that pertain to our responsibilities. We regularly provide DFAT and PM&C with support for a variety of briefings, including for the Prime Minister.

Senator RUSTON: So you have provided input to the briefing for the Prime Minister for his visit to the US.

Mr McIntyre: We don't have visibility of the briefing that they provide, but we do answer the questions they ask us, which they then use for a range of briefing products.

Senator RUSTON: Minister, did the government make a formal submission into this process?

Senator Green: That's a question for the minister tomorrow during DFAT estimates. What I can say is that we're obviously working extremely hard on it, and that we will not negotiate on the PBS.

Senator RUSTON: Okay. Secretary, in relation to one of the 70 reviews—the HTA review—have I got the right people here still? Yes. Which of the measures that were announced by the minister in September will lead to immediate faster access to medicines for patients?

Mr McIntyre: The minister announced a number of measures that are aimed at starting early implementation of some of the recommendations. Of course, these recommendations are interlinking and they need to be seen both individually and as a whole. That's why he established the implementation group to support that process. He's made some initial announcements, and we can talk about what he's announced. All of those things feed into improving access to HTA.

Senator RUSTON: Are there any measures that you can point to, that have been announced as part of the September announcement, that will lead to immediate, faster access to medicines for patients in Australia?

Mr McIntyre: They do support that. For example, the minister announced that PBAC would begin a rolling review of their guidelines, starting with those guidelines that are most important for sponsors in helping them to direct the way in which they put forward applications. If that guidance leads to greater clarity for sponsors, sponsors will be in a better position to put forward applications for PBAC that allow for more straightforward scrutiny. That would, in turn, improve the ability of sponsors to find acceptable the recommendations that PBAC might have. It's not going to be a one-to-one, straightforward—that we can do a particular thing and that will then, straightforwardly, lead to faster access. But what we're doing is addressing those areas that have been identified as pain points and seeking to make those pain points easier for pharmaceutical sponsoring firms to address.

Ms Shakespeare: One of the areas is trialling new ways to streamline the assessment of medicines, which we think will lead to faster assessment and listing of medicines on the PBS. Mr McIntyre has mentioned updating the guidelines for the PBAC, which set out in detail how it does its work, to focus on comparative selection and discount rates in the first instance because, as Mr McIntyre said, those are important for sponsors of medicines to bring forward medicines to the PBS, as is defining high, unmet clinical need and high therapeutic value so we can focus our efforts on medicines that meet those definitions. We have to consult with sponsors, with patients and with patient groups to make sure we all agree where we should be focusing our efforts to speed up access to those medicines that will meet high, unmet clinical need and have high added therapeutic value. There are a range of things that were announced in September that we think will lead to faster access to important medicines.

Senator RUSTON: Between the two of you, you've just told us that you're going to have a rolling review, you're going to update guidelines, you're going to trial something, and you're going to define 'need'. You really would understand why stakeholders are feeling incredibly underwhelmed and frustrated by the lack of concrete reforms and progress under the HTA review. This has been on foot for some time. It's been over 12 months since the report was delivered. At the 12-month anniversary of the report being delivered, you've just told me that we're going to have reviews, updates, trials and definitions. I understand that the minister noted that the final implementation road map is expected to be provided to government by January. Is that correct?

Mr McIntyre: By the end of this year, yes.

Senator RUSTON: So it will be December, not January?

Mr McIntyre: That's the announcement he's made.

Senator RUSTON: Has the government indicated a commitment to release that report in full?

Mr McIntyre: My colleague may remember whether the minister has announced that he intends to do that, but it's worth noting that he has released the interim report that was provided by the implementation group, and he's also provided the covering letter that was provided by the chair with advice about early implementation. So the minister has demonstrated his intention to be transparent about the advice that he receives.

Senator RUSTON: I just, particularly about the road map—

Mr Comley: I think what Mr McIntyre's meant is that there has been no formal commitment made at this stage.

Senator RUSTON: In terms of MRI licensing and services, can the department provide any further details around the budget measure 'affordable access to Medicare-eligible magnetic resonance imaging, or MRI, services at three metropolitan locations' that was announced?

Ms Warner: The government made a commitment in the 2025-26 budget for eligibility to be brought forward for three Medicare licensing arrangements for three machines in Lakeview Private Hospital in New South Wales, Barwon Health North in Victoria and Sandringham Hospital in Victoria.

Senator RUSTON: How will affordable access be delivered?

Ms Warner: These machines will become Medicare eligible ahead of when they would become eligible on 1 July 2027. They will become Medicare eligible two years ahead of when they were scheduled to become Medicare eligible.

Senator RUSTON: Why were there only three locations selected for this bringing forward of the affordability component of MRI?

Ms Warner: It was a government election commitment.

Senator RUSTON: Minister, do you know why those particular three locations were selected?

Senator Green: No. I can take that on notice for you.

Senator RUSTON: In terms of providing advice to the minister or the government in relation to these, did the department provide advice to the government or the minister in relation to these three locations?

Senator Green: We'll take that on notice.

Ms Warner: A number of locations were discussed with the office, and these were three of them.

Senator RUSTON: Did the department provide advice to the minister to say, 'Here are a number of locations where you can consider bringing forward the access to the additional affordability of this service,' and the government chose three of a number of sites that were put forward? What was the criteria on which the decision of the whole suite of sites was determined? What was the basis for why you would choose these sites for recommendation?

Ms Warner: The government looks at the location of other MRIs in the area and makes a decision based on the number of Medicare-eligible machines that are already located in that area and when ones would be opening up in the future for Medicare eligibility.

Senator RUSTON: So it's a relatively lower access to service for that area?

Ms Warner: Generally, yes.

Senator RUSTON: Were these three the areas with the lowest rating in terms of nearness of alternative service?

Ms Warner: They were considered to be in a group where they had low access in a range of—

Senator RUSTON: When you say 'low access', it's below average bulk-bill access to MRI services. Is that what you're saying?

Ms Warner: It's access to Medicare MRI services. Access to bulk-billing didn't come into the equation.

Senator RUSTON: So it's access to any MRI services regardless of whether they are subsidised or not?

Ms Warner: That's correct.

Senator RUSTON: Who ultimately determines the locations or decisions of granting the licences—the minister, you just said?

Ms Warner: Correct.

Senator RUSTON: So, when the decision was made for Sandringham Hospital to be one of the hospitals that would be granted this early access to subsidised MRI, did the Sandringham Hospital at the time have an MRI machine?

Ms Warner: No.

Mr McCabe: A lot of the locations have MRI machines. They're just not eligible for a Medicare rebate.

Senator RUSTON: That's my point, Mr McCabe. I'm interested why you would've given a subsidy or the affordability opportunity to a hospital that didn't have an MRI machine. You've given a licence for an MRI machine to a hospital that doesn't have an MRI machine. Are there any other sites where an MRI licence has been granted to a site that didn't have an MRI machine?

Mr McCabe: I think, historically, yes, there has been. Over numbers of years governments have made decisions to allocate licences and that, in some instances, makes Medicare rebates available to those locations if they have a machine. In other instances it allows the facilities to make investments to get an MRI machine because of the subsidy.

Senator RUSTON: Could you provide the list in recent times of the MRI licences that have been issued to facilities that don't have MRI machines?

Mr McCabe: We can take that on notice, Senator.

Senator RUSTON: Sure. So Lakeview in Sydney—which electorate is that in?

Mr McCabe: We'd have to check.

Ms Shakespeare: We'll have to take that on notice. I'm sorry, Senator.

Senator RUSTON: Barwon would be Corangamite, would it?

CHAIR: It sounds like the officials are taking it on notice.

Senator RUSTON: Yes, and Sandringham. I'm just interested, because I contend they were all in extremely marginal seats.

Senator ANANDA-RAJAH: Sandringham is Goldstein.

Senator RUSTON: Yes; Goldstein was held by Zoe Daniel prior to the last election.

Senator ANANDA-RAJAH: But Sandringham is also Alfred Health—I worked there. It doesn't have any MRI. It's a really busy hospital. I worked there for over 10 years.

Senator RUSTON: Does it have an MRI machine?

Senator ANANDA-RAJAH: There wasn't an MRI. There was a CT scanner.

Senator RUSTON: Funny about that.

Senator Green: Now there is going to be.

Senator RUSTON: Okay. I'm interested to understand why the decision was to bring it forward for these three locations, but other metropolitan areas—in fact the majority of metropolitan areas—have to wait for another two years for this to take effect. What was the basis for that decision? A decision of government?

Mr McCabe: It was a decision of government, Senator.

CHAIR: Thank you. That concludes today's hearing. Thank you to all the witnesses who have appeared and to Hansard and broadcasting for their assistance. I remind senators that the committee has agreed that any written questions on notice should be lodged with the secretariat on Thursday 16 October 2025 and that answers to all questions on notice are due by Friday 28 November 2025.

Committee adjourned at 22:39