Vision Summit with the Coalition

Questions & Answers Transcript Summary

Mr Dutton's introductory remarks

I just wanted to say a couple of words and then by the brief that was sent through obviously a number of questions, and diverse questions, that people have to ask and I want to do justice to as many of those as we can. So allow me just to speak very briefly and then to move into those questions and provide a response as best we can.

As we've worked with Vision 2020 for a period of time it has become apparent to all of us that really there is no separation of view in terms of the way in which we should proceed.

Vision 2020 covers obviously a broad based membership and has the experience and the ability to bring together in a collaborative way and list priorities that perhaps not everybody is pleased with, but nonetheless that represent a majority position from the organisation. And from our perspective as a Coalition both in opposition and if we're successful at the next election it would be hard for us to argue with those priorities; that's the first point for us to make.

The second point of course is that we are on the eve of an election whenever that may be, the end of next month or perhaps later in the year. The difficulty, of course, is that not just in this area but right across the health portfolio and indeed right across government, stakeholders have an expectation that policy will be announced in good time, which of course it will. The difficulty from an opposition's perspective in particular is that we don't yet know what the starting point will be and for those people who aren't familiar with the political process, and many in this room are, we don't get the starting point, if you like, what the bottom line will be, until 10 days after the writs are issued and I think it's a point that's often lost on people because we know that the starting point may be $10 or $15 billion different to what the budget provided in May.

So only a matter of few months apart, but nonetheless some of the assumptions around revenues from mining tax, government's now proposing potentially to abolish the carbon tax and to bring in its place an ETS, there are other issues which will impact otherwise in terms of growth, projections and the rest of it. The point that I make out of providing you with that information is that yes, we all have in our respective portfolios a number of asks and in particular in the health portfolio the list is quite lengthy.

It's lengthy in relation to indigenous Australians but rural medicine in particular, it's also particularly worthy in terms of our commitment to primary care and the way in which we want to invest in primary care to try and stop some of those

preventions into expensive tertiary settings, but more importantly to allow people to live with dignity and to live well and to avoid some of that illness if there is a better collaboration with those primary care providers. But I can't tell you today, and my colleagues can't tell you today, how far down that list we could work until we know what that starting point is.

So, I just wanted to provide that with you by way of background. That is the case as I say across portfolios but in health we have literally hundreds of stakeholders, many worthy asks and in the area of vision in particular there are some compelling asks particularly around indigenous and rural communities where there is at best a maldistribution of work force, certainly a lack of infrastructure, but no lack of desire across the community to make sure we improve those health outcomes.

Eye Health Survey

Question

Recommendation 1 in our (Vision 2020 Australia) mainstream proposal asks for $3.09 million in funding for the undertaking of a national eye health survey.

On DoHA's website, it says that the Health Surveillance Fund supports a quality health system through effective implementation and management of the government's key surveillance and monitoring priorities. It will enable improved detection, prevention and awareness of communicable and chronic diseases, and provide information and analysis to assess the efficacy of population health programs and to support evidence-based preventive health policy in Australia.

Current eye health data dates back to the mid-1990s. A National eye health survey will provide a current baseline and track progress towards the reduction of avoidable blindness and vision impairment by 25 per cent by 2019 and effectively report the data required in the WHO Action Plan 2014-19. Given the importance of undertaking a national eye health survey will you commit to funding this survey if you are elected?

Answer

[Dutton] We are not in a position to commit to it today, but there is no doubt firstly about the need for that $3 million to be spent, there is a question about whether or not the funding could be provided as you say rightly from the existing funding pool. Again, the difficulty for us in opposition is that we don't have any advice about what money remains in some of these funding pools and I suspect that that money has already been expended but none the less the Coalition would, if we are able to afford to do so, to support that recommendation because I do think it is important both in terms of us as policy makers but also clinicians and service deliverers on the ground to make sure that we have priorities right, that we understand the populations that we're working with, that we can prioritise in an area where there is enormous demand, but the reality for us is that even out of senate estimates and questions on notice, we've not been able to get up to date figures on what money may remain in some of these funds and it's not just here but in some of the infrastructure funds in particular, anecdotally groups are being told that the money has been expended, but that doesn't equate with some of our calculations.

The Government also announced in the Budget a contingency reserve. If you like, money that they've set aside for election announcements, and we don't know whether or not some of that money has been hypothesized, if you like, across to that fund to allow some funding

announcements. Now that might give us some flexibility but again we won't know until those figures are released in that PEFO (Pre-Election Economic & Fiscal Outlook) figure. There is no argument from us in terms of the need and if we can afford to fund, then we will do so.

Medicare

Question

Diabetes contributes to vision loss from diabetic retinopathy and other eye diseases associated with diabetes. Diabetes also has serious economic consequences for the individual, their families and for Australia at large.

There is considerable evidence that people who are at risk or diagnosed with diabetes actually are not always examined for diabetic retinopathy, and consequently do not receive best-practice treatment and management in accordance with the Australian Guidelines for the Management of Diabetic Retinopathy.

What financial mechanisms do you propose to use to actually stop the development of this risk and complication?

Would the Coalition consider including an item number for retinal photography into the Medicare Benefit Schedule and establishing access to the image for health care providers through the future Australian electronic patient record system?

Answer

[Dutton] In relation to primary care and in particular management of those who are presenting with co-morbidities or chronic diseases where we can identify there is a significant investment required, our stated objective, and I've repeated this ad nauseum around the country, our objective will be, if we win the election, really to concentrate on primary care both, so it gives us the ability to provide savings in the medium to long term, because I do think that the evidence is well and truly accepted and mounting about the need to keep people out of tertiary settings, if we can do that. But there is an obligation for us, particularly in the area of diabetes and the complications that arise from it, and in heart and cancer and elsewhere, to make sure that we have some greater flexibility about the funding that we can provide clinicians, particularly in the primary care setting. It differs quite dramatically from practices within a hundred yards of here compared to those thousands of kilometres away. So there is an opportunity for us to provide some flexibility in some of the proposals the Coalition is looking at, at the moment.

I would make a general comment about the approach if we win the election and that is that we want to restore integrity to some of the independence around PBAC, and I think also we would continue, it's fair to say with certainty, that we would continue to honour MSAC processes and to take the advice of experts within particular fields. I think that is particularly important because I think it's very difficult for the Health Minister of the day to second guess the advice from the health professionals.

In the end, the Health Minister is not a doctor or clinician practicing, and despite, again maybe having some predispositions and a want to support in some areas, I think people are best guided by the expert advice in the area, and if your expert advice is to us that this is a priority for us to invest into then we need to be able to be in a position to work with you and identify some of that flexible funding tool that perhaps we can create going forward so that we can address that at a primary care level.

[Audience comment: There is an application into MSAC, at the moment, for funding, for retinal photography that's been endorsed by the OAA, RANZCO and so forth and I believe that will go out to public consultation in the next couple of weeks. So that is an application that has been processed, so hopefully when it gets approved in six months, or however long it takes, it will rapidly go through cabinet.]

Question

Can you guarantee that people will have access to blood glucose monitoring strips and targeted blood glucose education to ensure that people continue to be able to manage their diabetes, take action as required and minimise diabetes complications such as diabetic retinopathy for the future?

Answer

[Dutton] The short answer is "yes". Our policy is to provide a continuation of that funding and to provide certainty to patients, and to those who are administering the scheme as well.

People from time to time raise issues about the most efficient use of some money under the scheme, and we're happy to have those discussions, but again, I think we've seen too much of that sort of the element of surprise over the course of the last five or six years. I think there is no value at all in having policies announced which are going to split a profession, or split a particular stakeholder group.

We need to sit down to regain the confidence I think of some of the providers of health care services in this country, try and reignite some of that goodwill that was there in 2007-8 and I think if we can do that then we can be guided by the best advice possible and if your advice to us is again, along with the other stakeholders, that there is some element of that spend at the moment that is better directed then I'm happy to have that discussion. But my advice to you is that on all the evidence that I've seen, there's an efficient way in which we are dispensing those services at the moment under the scheme and we would propose to continue that funding.

Question

Keratoconus is a degenerative corneal disease that is estimated to affect 15-20,000 people in Australia. At present, many people with keratoconus are unable to obtain adequate treatment to correct their vision. This means that many people are unnecessarily unable to work or study and experience higher rates of depression than fully-sighted people.

Unlike many other common and debilitating eye diseases (glaucoma, age-related macular degeneration) keratoconus is generally diagnosed in early adolescence. As such, people with keratoconus face a lifetime of costly optometric and ophthalmologic treatment for vision loss caused by the disease.

Specialised contact lenses are the primary remedy for keratoconus-related vision loss. Yet numerous patients are unable to access affordable contact lenses. Private health funds consider contact lenses a 'cosmetic alterative to glasses' and rebates are sometimes less than that for reading glasses. Worse, keratoconus is not even recognised as an eye disease by Medicare and low or zero rebates on all treatments reflect Medicare's failure to acknowledge its existence.

This contrasts the situation in many other Western countries, where keratoconus is recognised at government level as a serious eye condition meriting special attention. Both NZ and the UK

have schemes in place to subsidise the cost of contact lenses to patients – many of whom need to change their contact lenses several times a year.

While the number of people affected by keratoconus is not as significant as many other leading causes of vision loss, a relatively small investment and commitment by Government will make a significant impact to the lives of many Australians.

Vision 2020 Australia is recommending funding for services and supports for people who are blind or who have low vision and Keratoconus Australia would like to see specialized contact lenses included in this list of supports. This, in turn, will also reduce unnecessary corneal transplantation for keratoconus in a context of an acute shortage of donor tissue.

Is this Coalition prepared to recognize keratoconus as an eye disease through Medicare and fund specialized contact lenses for the treatment of keratoconus? If so, on what basis, or under what scheme will this occur?

Answer

[Dutton] I thank you for the question. When I read through the little bit of detail it escapes me as to why there hasn't been recognition already and perhaps you and others or Andrew who's got a longer corporate history in vision could explain to us why that's been resisted. People have been advocating, no doubt for a long time. In terms of the private health insurers I think one of the points you made in your submission was around the fact that there wasn't the ability for private health insurance funds to fund because they view it in a different category, if you like.

That is something that we can undertake to work with private funds on, to look at how we might provide greater assistance in terms of that on-going cost. I'm very happy to commit to that. In terms of Medicare item numbers and recognition, we would propose to continue the same processes as they were under our government, as they are under this government, in terms of deciding whether or not we can provide the funding. At a higher level I would like to engage more with you about how we can give a greater recognition.

[Laming] Thanks for that question and I just wanted to acknowledge that this has been a ten year battle for Keratoconus sufferers. Part of this lies within the unique Commonwealth-State divide that we have at the moment, which is that aids and appliances were typically provided by state governments and secondly that Medicare itself isn't usually an agency to recognize diseases, per se. I mean diseases appear in Medicare schedules for purposes of eligibility to an item but not necessarily to recognise the disease. I don't think we try to re-vision Medicare to do that, but it's important that we acknowledge the real case, the cost effectively case needs to be driven through the consultative committee that's made up of your ophthalmologists and your optometrists and they would put these recommendations forward as being cost effective. First of all we need this evidence of the averted corneal transplants that would occur with better management of contact lenses.

Secondly, Medicare goes half way there in that it does fund, for instance, myopes of greater than 5 dioptres, a refitting and revision of contact lenses that aren't related to a change in power, so if it's a material failure or change, that level is covered. Then you have the tax office approach, which is the net medical expense tax offset used to be in place for people who had significant expenses over and above the Medicare safety net and that was 20 per cent of all expenses over $1500, which was phased out in the most recent Budget over the next two

years, so I think that would further expose Keratoconus suffers now, because they don't have that option either. But, look, increasingly the challenge is that we've always looked to States to provide these arrangements, where in Victoria for instance the Victorian College of Optometry runs the scheme that looks after high need Keratoconus patients in that state and it's been a state by state arrangement.

Look, probably it makes sense to provide an economic case why it's better done in a different way, but that's yet to be done and with respect, I might have missed something, but I've never seen the economic case for managing Keratoconus patients differently and the potential for these, effectively, devices to be recognised through a federal scheme that might be more cost effectively done.

At the moment people just have to work through the State system and hope that they're eligible for some assistance and that's extremely patchy, so we're acknowledging that, it's been a long term problem but I think you need to run that case through the optometrists and the ophthalmologists because ultimately they're going to take the lead on that being a cost effective spend for the system, and I'm yet to see that presented.

Question

Currently, funding is provided to undertake several cancer screening programs, in specific populations across Australia. The cost-effectiveness of general population screening for glaucoma has likewise not been clearly established but there are certain high-risk populations where the "number needed to screen" would be at least as favourable as those for bowel, breast, cervical and prostate cancer screening. For glaucoma these are likely to include those with a positive family history and possibly those of advanced age.

If the case for glaucoma screening in high risk groups could be made, what is the likelihood of a national health screening program being funded? If that likelihood is high, what do we have to do to make that case, and with whom?

Answer

[Dutton] I suspect the latter part of your question is the most pertinent so the Treasurer of the day I suspect would be the person to whom you would have to plead the case, or at least the Health Minister would. You're right, in one sense it's a no brainer, it's similar to some of the research, the genetic research that's being done at the moment.

The requirement for additional research dollars there is, in my mind compelling and I think there is an opportunity for us, perhaps in a way that we haven't explored in the past, around Glaucoma but vision in general in terms of the research that's being conducted at the moment on a shoestring budget by some organisations, I think there is an opportunity for us to provide greater support, to go to the next level as you say, to provide population-wide screening or a targeted population-wide screening in terms of those who have got a genetic predisposition and I think we would be happy to have that discussion, to look at some of the economics of it, because obviously there's a significant health outcome but it costs savings otherwise.

So we would be very keen to see what sort of numbers might be involved and it comes back to then an issue of education generally because there are many disease groups that come to us about the need for us to provide support, just so people essentially can get the information from either a general practitioner or from a secondary clinician, or indeed just from the internet from some of the support groups. I mean, a dearth of information that's not yet

accessed properly, so I'd be happy to look at different ways in which we could provide assistance either through testing or through education or though research.

[Laming] The Agency for Healthcare Research and Quality (AHRQ) in the US is the most recent information we've got. Your question with the "if" was really important and still there isn't the randomised control trial to support any of this screening yet and the only finding from the US was that of the six key questions optic disk photography appears to be cost effective, so at this stage that is the one element that has been supported, but not screening yet and that data needs to come.

Workforce

Question

Access to primary eye care in some rural and remote areas remains limited and in others is only enabled by the Government's Visiting Optometry Scheme (VOS) which has been supporting vital access to primary eye care in rural and remote areas since the 1970s. Both the rural optometry and VOS workforces are ageing. Targeted effort is needed to ensure the sustainability of these workforces and attract more optometrists to the bush. The types of incentives needed to attract health practitioners to rural areas are well known and are already available for doctors. The recent Mason review of Government health workforce programs recommended they be extended to non-medical health professions. Minor amendments and additional investment in the VOS program would support training and mentoring for a sustainable workforce. What would a Coalition Government do to support a sustainable eye health workforce in priority rural areas? Will a Coalition Government commit to the minor adjustments needed to the VOS to ensure a sustainable VOS workforce?

Answer

[Laming] To your first question, we're very, very clear that the primary healthcare focus of VOS is really important and that merging these schemes into one may dilute that. The second part of your question really focuses on where these high need areas are, and I'm not yet convinced that we really know where these high need areas are nor that MSOAP and VOS can respond to that, so we don't yet do a real gap analysis to say we if had to put an optometrist somewhere in Western New South Wales where would it be. I'd really like to see that developed. And then finally, when you talk about small changes to the VOS, I would be highly receptive to look at that, but if that come with a cost neutral tag on it, we are even more keen.

Primary Health Care

Question

The current Government has made policy commitments to enhance primary health care, recognising that in the long run, in terms of health outcomes, this is the best use of scarce health resources. Of vital importance is better connectivity between primary health professionals to avoid duplication and ensure time and cost-effective care pathways.

Will the Coalition honour current Government policy commitments to strengthen primary health care and how will it act to strengthen primary health care, particularly the integration of practitioners, like optometrists, with GPs and pharmacists? Would a Coalition government include optometrists in MBS telemedicine eligibility?

Answer

[Dutton] The short answer is “yes”. I mean, one of the things that I find most clunky about the current health system is that we just don't have the ability to respond, particularly in terms of the funding models, to the emerging technology. We don't have the ability really to properly analyse where good money is being invested in the United States at the moment, but in other parts of the world there is some amazing innovation coming with smart phones and technology that I think we just lag too far behind in this country.

Now, there is an opportunity for us to work with primary care in particular. Medicare obviously has some issues around the efficacy of some of the programs and how demand will be dealt with and ways in which we could remunerate, the pricing structures, and the rest of it. So I think there is a lot of thought that is required but there is also a significant commitment from the Commonwealth, both under the previous Coalition Government, under this Government in terms of electronic health and frankly I think for the money we have spent so far we probably, as a nation, should expect more from the use of electronic health records, remote monitoring and the way in which some of the health services at a State-level are at different stages of progression in terms of their utilization of that medicine, particularly back to rural and indigenous settings. But in eye care there is an opportunity for us to particularly go into a greater way in indigenous communities, but remote communities otherwise where technology exists but at the moment, as you point out, the funding model doesn’t.

So we would be keen to work with relevant stakeholders to discover how we could on a trial basis perhaps do something more meaningful than what we are providing at the moment. So a real desire to see some improvements in this area.

[Laming] Once again it’s around the evidence, so if optometrists are going to be the primary care providers, on the one hand the other question is if they’re involved in telemedicine, are they still the primary care provider or are they now the specialist who’s getting the images at the other end? So whether it’s disc photography or fundal photography is the optometrist now remote? In which case who’s the primary care provider? If we’re going to send these images away for secondary reading, who is the person with the greatest sensitivity and specificity to do this in a cost-beneficial way? Optometrists may be very competitive, but we need to see that surface provision research to prove that.

Research

Question

Why is it that a first world country like Australia, that has an amazing track record in science and innovation, is not funding research into curing inherited blindness?

Australians called out for, and support, the Australian Inherited Retinal Disease Register and DNA Bank, an innovative initiative that could be the platform for curing inherited blindness and numerous other diseases, both in Australia and overseas, so we ask if this initiative could be funded in the near future?

Answer

[Dutton] I have to say that medical research is one of those things that the Coalition remains very passionate about. Tony Abbot has maintained an interest in the health portfolio as Leader of the Opposition, which is sometimes a good thing and bad thing for a Shadow Health Minister to have a boss that knows what they’re talking about, but in terms of medical research, we

significantly increased medical research when we were in Government.

We blocked the government's attempts in 2011 to cut money from medical research, and we announced only a couple of months ago in Melbourne that we would quarantine medical research from any budget cuts given that we're in a very tight fiscal environment. I think that whoever wins the election will be in that situation for the next foreseeable future.

So, our ask from the NHMRC and others will be how we can try and prioritise some of these areas that perhaps haven't been seen as worthy in the past to understand that efficiency in the application process it is a particularly competitive arrangement as you know, but our desire is, we've announced recently $35 million more for juvenile diabetes research in terms of clinical trials and we want to make sure that if we can afford to do so, then we can put some more money into medical research.

It is absolutely at the core of our belief in how we can try and provide assistance to our population. So again I'm very happy to work with you, I've read a little bit of what you've provided to us but I'd be happy to explore that further and see ways in which we might be able to provide assistance. Because I do think it's an area that's under-funded at the moment and I would be very keen to see how we could work to put more tangible support in place.

PBS

Question

I'd like to know why there is a limit for PBS on treatments like Lucentis for age related macular degeneration?

Answer

[Dutton] Well, I'll just make a general comment because I know that people have an interest in a number of different molecules and listing processes. The objective of the PBS reform was to try and provide some certainty around the listing process, so that it wasn't politicised. I think sadly it has been over the last few years. For the first time the Government's taken the decisions to ignore the independent recommendations of the PBAC.

I think that's been unhelpful and I think it has added to some uncertainty both in terms of companies that want to put money into research and into a listing process. In the end though, the amount that we can spend on the PBS has to be sustainable. I believe that the PBS is on a sustainable path, if the Coalition is elected we will well and truly revert back to a process where an independent PBAC can analyse the information as it's provided, by way of the applications and then make a decision about the listing process from there.

Where there are anomalies that exist and I understand the past debate about Lucentis, but where there are difficulties or anomalies that exist then it's the responsibility of the minister of the day to try and resolve those as best they can, but in the end the guiding principle will be, that if we have a funded independent body that assesses the efficacy and the cost effectiveness of drugs, then the government of the day should adhere to that advice and that's the principle that we would adopt, if we are successful at the election.

Awareness

Question

Diabetes contributes to vision loss from diabetic retinopathy and other eye diseases associated

with diabetes. Diabetes also has serious economic consequences for the individual, their families and for Australia at large.

There is considerable evidence that Australians diagnosed with diabetes who are not examined for diabetic retinopathy, and consequently do not receive best-practice treatment and management in accordance with the Australian Guidelines for the Management of Diabetic Retinopathy. Would the Coalition consider:

Facilitating a public education campaign to increase the number of people with diabetes who are examined in accordance with the Australian Guidelines for the Management of Diabetic Retinopathy?

Answer

[Dutton] You will be pleased to know that not everybody that comes to see me but certainly, say 99 per cent, ask for an education or awareness program, so much so that I could fill our television screens for years to come, I suspect. The reality is that there are a lot of common messages though when people come and talk to us regardless of what disease group they are from, so people talk about diet and sedentary lifestyle, awareness of medication usage, regular contact at particularly different age groups with doctors or nurses or other allied health professionals about prevention and ways in which they can manage their conditions.

It is really at the heart of why we want to inject as much money as we can into the Primary Care space.

I've been critical of the Government over the course of the last few years, because we've seen a 27% increase in the number of bureaucrats in Canberra. It wasn't that long ago that we had three agencies attached to the Department of Health, there are now eighteen. The Department of Health not too long ago had 3100 staff, they've now got 6400 and we had two departmental secretaries, there are now six.

I have tried to be as honest as I can in this space because I really do think we need to judge where money is being efficiently spent across the system but, in particular, in what has now become a multi-billion dollar recurrent spend in that area. We have now got an addition of 3000 people on the Medicare local network and the government won't tell us exactly what each of those people, the services, that they are performing.

I think there are some legitimate questions to be asked and the reason I make that point is that I think if we can free some money up from back office operations, if you like, I think that is the way in a constrained economic environment in which we are going to create some greater awareness. We are going to make it easier for people to have a more meaningful relationship with their primary care practitioner.

I think that if we can do that then we can get some better health outcomes, not just in vision but across many disease groups and I think that is what has driven us and hopefully that is what will come through in the theme of our policy announcements when they're made in the election. But can I say to you that we can commit to a $15 or $50 million advertising campaign? I can't make that commitment today, but I can say that the absolute driver for me in this portfolio and for my colleagues in this portfolio is to make sure that we can recover every dollar and return it to frontline services so that we can fund some of the priorities that people have spoken about today.

Indigenous

Question

The recent National Indigenous Eye Health Survey detailed Aboriginal population needs for improved eye health and vision services through supporting the growth of the workforce to deliver valuable frontline services. Can you outline the commitment of the Coalition to improving Aboriginal eye health and what type of mechanism system or structure to monitor indigenous health, making sure that we continue making those inroads, not just from out in the services but the whole of the common health cases?

Answer

[Dutton] Just to give you a bit of that history, so before we came into Opposition, I was the Assistant Treasurer, so I sat in the expenditure review committee.

In the expenditure review committee for all the years that we were in government, that I was involved in – there was never a quibble about putting money into indigenous health care or housing frankly for that matter, or to try and improve some of the other social determinants otherwise. When you go into some of the communities, it is heart-breaking for any Australian to see kids living in some of the conditions, to see the way in which health services function – I suppose, people have goodwill and intent – but, generally, the experience in some of the communities is that people are just frustrated by not seeing greater improvements in time. So there is no lack of desire or intent, and this is an area that many of us are very passionate about.

Both in government or over our period in Opposition, we've provided bipartisan support with a lot of commitment that the government's provided over the last six years, as they did when we were in government, so I want to make that point, because I think that would guide us if we return to government after this election.

There is a lot of good work being done by NACCHO, by others in the space at a state and territory level; people who are contracted to deliver services, and the only guiding principle, for me, is to make sure that we can continue to help people who are most in need. So some of the prioritisation about some of the services being delivered perhaps, it's seen as sort of a national program at the moment. I think there's a much greater capacity to reprioritise and to put more money into communities that are remote or regional, that deserve more help than what they're getting at the moment.

So the guiding principle for me – and Andrew, obviously, deals in much more detail with the policy in this area, and he can talk in a moment – but the guiding principle, for me, will be to make sure that we reduce duplication where it exists, and there is a lot of anecdotal evidence given to us. I was in Townsville and Mackay in WA last week, as we move across the country - there is a lot of evidence provided to us about the duplication of services in terms of dieticians, podiatrists, and yet, in other areas, there is a complete lack of those services, so we need to get smarter about workforce, and, in the end, I just want to make sure that we're giving ourselves the best chance to deliver those services, and many of the established processes and delivery models that people have got on the ground, we would want to compliment, and we'd want to work with services to make sure that we are getting the most efficient spend.

That's the bigger picture from my perspective, there is no desire to cut money from this

space, quite the opposite. If we can pursue a better spend of that money, and a more efficient spend of it and it's going to deliver better health outcomes for indigenous Australians across the portfolio, then we'll be dogged in our pursuit. So, that's the guiding principle I suppose that I can espouse to you. People should be judged on their track record and our track record in government frankly is one which I'm very proud of and I know Tony is.

Tony's also spoken about ways in which if we win the election, some of the effort will be concentrated within his own department of Prime Minister in Cabinet. I think that will give it additional impetus and that way we can get the health outcomes that we all desire.

Question

Given that we are the major provider of health services to our people across the country, particularly in Queensland, I can safely say that we actually have about 65,000 of our people accessing community control services in Queensland. It demonstrates really that our people are coming to our services. We are the major provider of health care services. We are also then providing access to other rural pathways, health care coordination.

How will the Coalition's policy ensure support for Aboriginal community controlled comprehensive primary healthcare organisations and provide greater coordination and improved referral pathways and accessibility for Aboriginal clients?

Answer

[Laming] The question you asked is about the centrality of community-driven health care solutions up through the community sector. There's no hidden policy that says anything other than the centrality of the services that you're delivering and I've often said to the sector, in some ways you need to acknowledge that your results are the evidence.

It is why you're here. It is why you're now nation-wide, it's why QAIHC is now recognised particularly for some of the most cutting-edge reforms in community-driven health care by Aboriginal people. So you're doing all of the right things but without just giving unmitigated lip-service I want to say to you that any service or any model is only as good as its last annual report. So I don't want to give you the unlimited remit to say that things will never change.

You are proving yourself but you will need to continue to do that and part of that is the report card that you just presented. This is some evidence that we don't get from any part of the health sector. The work that you're doing for wrap around personally centred, holistic health care is not something that I want to remain a mystery within the walls of community-driven health care organisations.

I want you to take this approach to the rest of our health service because it would be a better health system if we did that. So, far from trying to preserve what you do, it's more important that the great reforms that you're delivering now are actually part of our greater health system and you need to be informing that so I would like to see the closest possible relationship. So all of those items you know about health checks and chronic management disease items, all originated under Tony Abbott and his work. They will need to continue, they will continue to be finessed. So increasingly the workforce is the number one issue you have chosen and something that we're really focused on fixing.

Question

This question is about monitoring and evaluation, whether it be a global, structure or actual monitoring of indigenous health improvement.

Can you please outline the commitment of the Coalition to ensure your information on the trend? What parliamentary/high level monitoring and evaluation mechanisms is the Coalition considering for chronic diseases, including vision loss?

Answer

[Dutton] The first principle by a Coalition government would be to try and devolve power as much as possible down to local communities. And I think that is very important principle because there has been a debate in our country about the Commonwealth taking over public hospitals. I think that would be a disaster, frankly. And we have said we want to concentrate on primary healthcare and I think the decision making needs to leave Canberra as much as possible because going back to some of the early comments that I made, in primary care across the board I think there is an opportunity for us to get some of those programs back to a local level so that we can make sure that as much of that money is directed to the areas of need. That's the first point.

The second point is that I think that then lends itself to better monitoring. I think frankly we should have better monitoring across the delivery of care in primary care and I don't think we should be afraid of that. We're seeing a much more transparent model now in terms of the provision of tertiary services. The way in which those services delivered, the cost in which they're delivered, infection rates, all other indicators which show us where money is being efficiently spent. I'm not hung up on how that data is collected, but I am adamant that it will only be collected by one source if you like, so that we're not asking people to replicate. I think there should be a central point where people are able to populate that data and I think frankly government should then at a state and federal level have the capacity to access that data. But we don't want people to be - and I think a lot of this has crept in frankly over the course of the last six years - collecting data and remitting it and it sits in a hard drive somewhere and it's never released. I don't think we should be afraid of having that publically scrutinised. And I think, frankly, if we do, we will drive better health outcomes than we've seen in recent decades. So, as I said, I'm not hung up about the way in which that data is collected, but I do want to reduce the administrative burden on health services across the board. I want to make sure that information is reliable, that it's auditable and that people can be accountable for it but in the end I think we will drive some behavioural change and I think we can also get some competitive tension going between people, highly trained some of the best clinicians in the world, if we make some of that data available and I think that's a debate that we shouldn't be afraid to have.

Question

We are pleased to see some inroads in the elimination of trachoma in population areas identified as experiencing endemic trachoma but know there is some way to go. Can you please outline the commitment of the Coalition to ensuring the elimination of trachoma in Aboriginal communities?

Answer

[Dutton] About trachoma - well, again I take you back to our record. If you look at Tony's record in trachoma, the Coalition government had no hesitation in investing money. We would propose to continue our investment to find how we can again more efficiently deliver the service, if it's not being done already; which I don't suggest for a moment, I'm just saying if we can drive our dollar further and the argument is made for us to put a greater investment in, then again there is just no moral or social or frankly economic argument for us not to do

more in that space and we should be getting better health outcomes than what we are at the moment, so we are completely committed.

Senator Fifield's introductory remarks

I think most of you know that the approach that I've sought to bring to the disabilities portfolio is as much as possible to seek to elevate it above partisanship. We have supported every milestone on the road to the NDIS: the launch sites, the legislations, the funding, even the increase in the Medicare levy. But we would have taken a slightly different approach had we been the government. We have proposed to the government about 18 months ago that there should be a joint Parliamentary Committee chaired by both sides of politics to oversee the design and implementation of the NDIS. We offered to the government to be partners in the design of the scheme, that offer was not accepted, so although we support the broad architecture of the scheme and the timeframe and the announced to spending money, the detailed design, the rules, the legislative drafting and the launch site implementation are the responsibility of the Government of the day.

We however, despite the fact we weren't part of the design through this joint parliamentary committee, still think that there is a role for a parliamentary committee to oversee the implementation of the NDIS and we are pleased that the government, about a month ago, agreed to establish such a committee to oversee the implementation of this scheme. It's not exactly what we had hoped for, the terms of reference are narrower than we had hopped and the timeframe that the committee will be in place for is shorter – it only goes for about two years. If we were successful at the election we would seek to expand the terms of reference of that committee so they could look at the experience in the NDIS launch sites including eligibility criteria and we would also extend the timeframe that the committee covered so that it would be in place for the full implementation of the NDIS to 2020.

So as I was saying, we would have approached things a little bit differently. Now I am aware that obviously there are concerns, amongst a number of people particularly around the age 65 cut-off for support through the NDIS. Part of the purpose of the launch sites is to look at how this scheme operates in practice; look at the interfaces between the health and the aged care systems, so we need to look and see if things need to be done a better way. The parliamentary committee that has now been established will, if we're successful at the election, play an important role in looking at those issues. It's also important I guess to bear in mind that the NDIS won't be fully rolled out until 2020 so there is a little bit of time to make sure that we do get this right. From our point of view, the commencement of the launch sites is very much the starting point not the end point of how the NDIS will ultimately look when it's fully rolled out. I don't think that there has been a terribly good job in terms of expectations management for the scheme.

That the NDIS won't cover all Australians with disability, there is about 4 million Australians with disability, this scheme will cover about 460,000 people but you could be forgiven for having the impression that it does indeed cover everyone, and I don't think that the $22 million which is currently being spent on the NDIS advertising campaign is helping that expectations management. The ads contain no information about eligibility and I think you are only serving to further ramp-up expectations and that's a problem for a number of organisations that are represented here today because if the community think that the NDIS covers everyone with a disability, they will be far less likely to put their hand in their pocket

and contribute to organisations such as some of yours, so that's a very important reason why any information about the NDIS should be unadorned and factual.

I will close on this point because I know time is short, but in relation to the issues of eligibility, over 65 in particular, I think there are few things that have to happen. Number one is we've actually got to get a handle on the mesh that currently is the case for support for people with vision impairment and blindness over the age of 65, a variety of different support arrangements state by state the NDIS introduces a new dynamic into that as well, so there needs to be some work done to establish the array of supports that currently are. There needs to be a mechanism to look at the experience in the NDIS launch sites and to see if there is better way for delivering supports and how the gaps between the NDIS and the Aged Care system can be filled and the other important piece of work is we need to know what the cost would be of doing something different. So I can't give you answers today as to what might be done, but I can outline that we do have in mind to progress to address those issues. Thanks.

NDIS

Question

The *DisabilityCare Australia - Support Clusters and Associated Pricing Document* for the Tasmanian trial has been released on the website and lists a number of support items that would be applicable to people with vision impairment, including 4 of the main 5 supports required (1. mobility training, 2. instrumental activities of daily living training, 3. equipment and aids and 4. counselling). Guide Dogs / Seeing Eye Dogs have not been listed and these are one of the key supports needed by people with functional vision loss.

To your knowledge, have dogs been intentionally left out of the support items covered by DCA and would a Coalition Government support Dogs being included as a covered item under DCA?

Answer

[Fifield] I think that the average Australian would be gobsmacked if they heard that the NDIS didn't cover dog guides. That would be one of the first things that would come into people's minds that an NDIS would provide – so from my point of view, they certainly should. I have at the last 2 or 3 Senate Estimates committees asked that specific question, to get it on the record whether the NDIS would provide dog guides for people who are eligible and I have been told yes, they would be, so I will be an optimist and assume that the NDIS agency simply haven't got around yet to listing dog guides as an eligible item.

Question

The blindness and low vision sector has openly congratulated the Coalition's support of DisabilityCare and the 0.5 per cent increase in the Medicare levy to help pay for its implementation, however Mr Abbott has voiced that this levy will be temporary under a Coalition Government. Will the Coalition be releasing details of how a Coalition Government will fund DisabilityCare to provide certainty that this landmark reform will be financially supported into the future?

Answer

[Fifield] I will, before I answer that, answer question that you haven't asked, which is – one of our misgivings initially about the increase in the Medicare levy to part fund the NDIS was I guess what you might call the Queensland flood levy effect, where people might think that we have paid our levy therefore the scheme is totally covered we don't need to put our hand in

our pockets, so I think there are two issues when it comes to fundraising for organisations: one is, the over hyping of the scheme, and the second is the impression that the levy covers the complete cost of the scheme, which it doesn't. The Medicare levy increase covers the Commonwealth's required additional contribution over the forward estimates period but, as you know, this scheme is progressively rolled out so the costs ramp up over time, so the levy will collect about $3 billion a year, the Commonwealth's additional contribution of full rollout will be an additional contribution of about $9 billion a year, so it covers maybe a third of the required additional Commonwealth expenditure, so whoever is in office will have to identify further savings to fund that difference and that's certainly something that we are committed to do.

Coming to your question Ron, whether the levy would be temporary under us, we've indicated that yes, it would be temporary until such time as the budget is in strong surplus and the NDIS, the Commonwealth's contribution to the NDIS, could be funded from existing revenues. So how long temporary is, I don't know but we are not going to pull the levy until the budget is in a position to fully sustain the NDIS.

Over 65s

Question

How will the proposed Aged Care services match the services that blind people over the age of 65 have already been receiving?

Answer

[Fifield] On the aged care side I can't tell you, not seeking to shirk it, but we do have a division of labour and Concetta Fierravanti-Wells looks after the aged care system and will look after our response to the government's living longer/living better package. But obviously I do recognise that with the age 65 cut off you can have someone who is 64 who gets supports and services for their blindness or vision impairment, someone who acquires their vision impairment aged 66 is in a different situation and that they rely upon organisations represented here who fund raise and also rely upon a range of state government services which vary from jurisdiction to jurisdiction, so it's patchy.

Why we are in the situation? I think the productivity commission when they were doing their original work were paranoid about the prospect of the NDIS taking responsibility for the aged care system as a whole and I think what drove that were visions of the NDIS taking responsibility for aged care accommodation. Now organisations like National Seniors, who work closely with a number of organisations here they made clear that they don't envisage the NDIS taking responsibility for aged care accommodation or psychogeriatric supports, which means that the issue of debatable discussion now really is about the supports and services for things like vision impairment, things like hearing impairment, so it's a much narrower range of issues which are really in discussion than I think productivity commission initially envisaged. I guess the good news, and tell me if I'm wrong, is that hopefully no one over the age of 65 will lose any of the supports that they currently have, so no one is in a worse position as the result of the NDIS, fingers crossed. I think that in fact, people over the age of 65 are in a better position than if the NDIS didn't exist, because the fact that we have the NDIS is going to shine a light in a way that wasn't happening before, about the disparity and the level of support between the disability system and the aged care system and the NDIS launch sites will be where that light is at its brightest. So I think that the cause of getting better supports, better

vision services/supports for people over the age of 65 is actually advanced by the NDIS, because of the focus that will be put on these issues.

As I mentioned in my remarks, the process that we will follow is, we will expand the terms of reference of the Parliamentary NDIS Oversight committee, so that it can look at the experience in the launch site, it can look at the interface issues between health and aged care in the NDIS and the parliamentary oversight committee will have the option of conducting its own enquires and making recommendations, but it's important that we commission work to find out what the cost would be of expanding vision support services for people over the age of 65 and then the next step after that is to see whether they're most appropriately delivered via the aged care system or via the NDIS. Sorry it's a long answer.

Question

The eligibility criteria for DisabilityCare Australia clearly state that cover will only be provided to support Australians who apply under the age of 65.

Would a Coalition Government support this 65 year old cut off in entitlement for DCA cover? And if so, would a Coalition Government ensure that the Department of Health and Ageing were provided with funding to cover people with vision impairment applying for similar support to that offered by DCA but who were over the age of 65.

Answer

[Fifield] I think that the parliamentary oversight committee would be a good mechanism to pursue that with, I think one of the compelling arguments for additional support for people over the age of 65 is on the basis of cost – that it's a lot less expensive to do home modifications for someone or to give them equipment that can help them read, than it is to say "Oh well, they've lost their sight. We'll have a personal attendant/carer come every day and do things for them". So I think that the cost argument is clear, but the parliamentary oversight committee I think would be a good mechanism to do that.

In conclusion, I don't see the election date coming up as a deadline for us as an opposition to have an answer to the over 65 question, sometimes election days are seen as a bit like an exam that stakeholders and the opposition have all got to cram and get their answers and responses ready by election day. I'd rather take the time to get it right and flag before the election that we do recognise that this is an issue and that there will be a mechanism to address it.

The Hon Teresa Gambaro MP introductory remarks

Thank you very much Jennifer. Barry, I would like acknowledge you in his absence, Peter, Mitch and also Andrew, thank you very much for inviting me along here today and I am delighted to be standing here and working in this portfolio and I recognize many familiar faces that I worked with several years ago that was before the 2007 election when I was Parliamentary Secretary for Foreign Affairs with Alexander Downer and then I got involuntary retired or dumped at the 2007 election, became a fishmonger, and have come back to the portfolio in the Shadow area with fresh eyes. And I will just give a little bit of a guide as to what our policies are in this area, and where I have seen the foreign aid portfolio change over those intervening 5 years and bearing in mind I was chuckling when Peter Dutton said he had one advisor, he's got one more than I have and are more than you Andrew, so he is absolutely brimming with advisors. But I must say it's very difficult from Opposition to get briefings from

secretaries, from department officials and a lot of the time we have to rely on our own research and, you know, other reports and advice. But our commitment to – in the 2010 election and I work with Shadow Minister Julie Bishop and she has the Shadow Foreign Aid portfolio and I work with her on the Shadow Parliamentary Secretary, the foreign aid area.

Look we went to the 2010 election with a commitment of 0.5 of GNI that – and it was a bi-partisan commitment from both sides of politics, we also went to the election with a commitment that there would be a special dedicated Minister for foreign aid the portfolio is too important, too big, too large and too significant in our Australian region not to have a dedicated Minster. It was really great to see Kevin Rudd pinch our policy the other day when he appointed a special Minster in that area for whatever time we might have to the election in Melissa Parke. But that has been our policy for the last 4 years.

In terms of the aid program and where it should be spent, our focus is that it should be spent in the Pacific and in our near neighbours and our region. We're the closest to that region, we can have the most influence in that particular region and Jennifer you were talking about the number of cases of preventable blindness and the fact that we were looking at 233 million and that roughly 34 million people the worldwide are blind. One of the alarming statistics that I read recently was a WHO report in 2011 that said that there is a huge link between mortality and blindness and the fact that 60% of children who become blind are dead within 2 years, and that is a staggering statistic.

But in terms of our commitment, it should be spent in the region. We saw a very audacious bid to win the Security Council seat, we saw a great diversion of aid - our estimate is that it is far more than has been revealed when we questioned our wonderful Senators - we sent them all these lovely questions to ask of the Department officials - we have estimated that more than 3 billion has gone from the aid program. When we look at all the redirections that were put in place to secure a United Nations Security Council seat, I mean, we have examples and I will just give you a couple because we have only a short amount of time - we have $65 million was spent on a telescope in the Chilean desert $150,000 on the statue in New York commemorating slavery in the Caribbean, they're just some of the things that you have to question: where is the overseas development aid in those particular programs? I saw a program in, not so long ago, in November, a multilateral program, where Australia had invested close to $30 million in building a railway in Cambodia, that is going nowhere. The most important thing in foreign aid is that it be effective and it be in our region. Where our focus would be, and I will speak about Peter Dutton, in his absence, he did release a medical research policy recently which I think we need to take medical research into the foreign aid area and particularly emphasize the delivery of health programs in concert with medical research, it hasn't been happening. We've got old methodology particularly, and Andrew I know this is an interest of yours as well, particularly how it impacts on Torres Strait Islander communities, extreme resistance TB, the test that we're using for TB is quite ancient and is close to 100 years old. There are new technologies in medical research that will help us develop more effective drugs out there and much more effective health delivery models. We pour a lot of money in foreign aid in health deliver models, what we need to match up with the medical research area.

We also – and there is one thing that we won't do and I will get partisan here, we will not hijack money. We saw $375 million diverted out of the aid portfolio to go straight into onshore processing in December of last year, and we also saw a pause in the Federal Budget – the Government's Federal Budget this year. We are – last year we were – Australia was a third

largest recipient of its own foreign aid. After the May Budget we are now the largest recipient on shore of our own foreign aid. Foreign aid should be for overseas development assistance and I repeat that all the time. We have some challenges in our region particularly in health - we have challenges with TB, AIDS, HIV and Malaria, we have treatment regimes that could be much better, we are rolling out health programs and I would like to see a better health deliver models particularly in PNG where we saw the outstanding increase in rates between 2007 and 2011 - $170 million was spent and we was the rates go up. Effectiveness is the key for aid; we need to have properly tailored programs, we need to have effective measures, we need to have benchmarks. And there is another area that is an area, maybe because I have come from the business sector as well, but we should work closer with the business sector and NGOs in delivering foreign aid on the ground. There has been some attempts made by AusAID at the moment, but I think that they have just resulted in gatherings, I don't think anything has been to advance the role of the corporate sector, particularly in their role in helping countries reach their development targets and moving out of poverty and becoming our trading partners in the future. When we see countries like China and we see countries like India move out of being recipients of foreign aid to now trading with us effectively.

I know we've only got a very short length of time, and I know there is probably a lot of questions in this area, but the aid program should be focused on disability - particularly in the areas of preventable care. Most of the cases of vision impairment in the world can be prevented but they also need to be linked with health and sanitation. They can't be treated in isolation and in particular in the Pacific region we also – and I know we've got a lot of questions about diabetes – but there are linkages again between diabetes and blindness, and there are huge rates of - diabetes rates, sadly are going up in the Pacific. I was very pleased to have done a lot of work when in government, making sure that was put on a WHO priority level and I was glad to see that advance to the WHO priority level. So thank you for inviting me.

Question

As you'd be aware obviously AusAID allocated $39 million in the last Federal Budget for specifically 10,000 sight restoring surgeries and 100,000 vision screenings. Unfortunately, we've not heard any more from AusAID on costing details or how that money will be allocated. So here is my question to you is, what would you be sort of putting forward for the spend of those funds? And particularly, in light of the other part of the proposal that was put forward by the sector, which specifically looked at other areas, evidence-based, and measuring the effectiveness, development of an appropriate and sustainable workforce and also significantly decreasing avoidable blindness in the region.

Answer

[Gambaro] Thank you for that question. I am afraid I am going to have to follow along the lines of the rest of my colleagues. It is disappointing to see that not much is being done. And from what I see about a number of AusAID programs there are some wonderful papers out there and there is a classic medical research paper that was put out in October, but we really have not seen much more of it. In terms of what we would do in government, should we be successful, we need to look at what the budgetary implications are at the moment. But look, this area is a high priority. I think when I was working with Alexander Downer, we started doing a lot of work in that disability sector in the start of what the disability policies within the foreign aid sector. Your organization, Brien Holden, and you guys do some really good work, in terms of

the international work that you have done in translating work into Spanish and Portuguese for optometrists and other workers internationally and I really have to applaud you.

You have to make sure that you train your workforce. You have to make sure you use online technologies. Partner up with universities or organizations in countries and I see the wonderful work that the Royal Ophthalmologists do, and I am giving them a bit of a plug, and many of the groups that do by partnering with organizations within countries. Actually, I was in the Solomans not last December, the December before, and saw a team from Tasmania doing great work so all of those health delivery systems, you have to have a better way of rolling them out in-country.

Question

You would know the publicly, an effective plan to engage the business sector in driving economic development is a primary leaver to achieve positive aid outcomes is needed. You've talked just now about engagement in the corporate sector and with NGOs. There are a lot of people in this room I think they're going to 'yep' because in the vision area we see the private sector as a really important role it plays in international development in the vision sector. We see the private sector driving the delivery of eye health services in China. We see foreign direct investment from China driving development in Africa. Every country we go to we see people making a living out of selling spectacles that get training and support and accreditation to support those private sectors initiatives, and that's fantastic. So we would like to hear a little bit more about your plan for engaging with the private sector and how we can support that. The second part of the question is of course about NGOs. NGOs, or nongovernmental organizations, receive about 6% of AusAID's budget at the moment. We receive support from over two million households who voluntary decide to support international aid organizations. But 90% the money expended by AusAID goes through multilateral and bilateral channels.

So I do want to hear from you, would like to hear a bit about your thinking of engagement with NGOs as a support for Australia's non-government organizations under a Coalition government.

Answer

[Gambaro] Julie Bishop and I have always said as part of our policy that there needs to be more engagement with NGOs on the ground in the countries where they work. They know the terrain, they know the set-up, they've been working there for years. And you're right, there is a very small percentage of foreign aid money that goes directly to NGOs. The multilateral area – from what I've seen works well in some areas and we have a commitment, very soon Australia would have to decide whether to sign up to the Global Fund in September, and I understand that the government has made no commitment at this stage to that.

But I saw a GAVI program in Myanmar in November which was very effective. What they do is they go to a country and make up a GAVI. Many of you know that a GAVI is made up of a public/private partnership and they go to a country and say "Look, we will give you two and a half million to roll out an immunization program. But we want to you, the government of the country, to match that and to work with us." The days of just throwing money at countries and hoping that they'll deliver an immunization program are gone. When people have ownership of it it's much more successful and I saw a very good example that in November.

There are some multilaterals and I gave you an example of that horrendous railway which I keep asking questions in Estimates. $30 million the last time I looked was put towards that

Asian Development Bank project. Now the French won the tender, the Japanese won the quality assurance, the Australians are responsible and Toll is responsible for making sure that when it is finished that they will have the freight and what you call the franchise – it's going nowhere. There are consultants engaged getting exorbitant salaries and are taking it very slowly. That's the worst example that I've seen.

The problem that we have is that once money goes into a multilateral, and I am not saying all multilaterals don't do a good job, once it goes into that pool you can't track whether it is effective or not and it is very difficult, and there have been reports on the effectiveness of a number of multilateral organisations. There was a report done recently and it showed a number of multilaterals did well, but there were a number that weren't doing so well so. I'd be concerned about just putting money into multilaterals. I mean, we've had evidence of that. Because this government's trying to ratchet up the foreign aid program, the easiest way to shovel money out the door is to give it to a multilateral. I'm not convinced that's the most effective use of foreign aid.

Oh the business sector. Look, some great work is being done in England through DfID and they're to be commended on that. My colleagues are deserting me. And what they're doing is engaging the business sector. That's not to say they're mutually exclusive - so the business sector doesn't take over where NGOs work. I think there's a great opportunity for them to work together. I was with the Deputy British High Commissioner recently who was telling me about a British company that had rolled out nets and a malaria program in Tanzania because a number of their workforce were being stricken with malaria and they rolled out this particular netting program. It's a pretty simple program, it's not terribly sophisticated, and it was so effective that the government then asked them to roll out the program for the whole of Tanzania. So, there are areas that the business sector can work and engage in and we saw the Reverse Colombo Plan a couple of months ago and some of you in this room attended that, the release of the Reverse Colombo Plan. We had 150 people in a room, a forum, and we had some of our best university academic NGOs in that room and they advanced some very good ideas and there now is a steering committee. I would like to see the corporate sector brought in.

When I first came to this I used to see a lot of the corporate sector doing incredible philanthropy, very ad-hoc philanthropy. They built a school, or they built a water sanitation system. And I thought, everyone's running around doing good deeds but there's no integration and I just thought of it from that viewpoint as givers of aid. But I've since come away and thought there can be a greater way of engaging the corporate sector not just as philanthropists but to being equally involved in helping with agricultural health programs, business programs, working in-country, making sure that we lift people out of poverty through economic development so one day they become our trading partners. But that's not to say that NGOs and the business sector are mutually exclusive to one another. I just want to make that clear.

Question

It's just a follow up question to Brian's. The main way that the government funds Australian charities in the international aid space is the Australian NGO Corporation Program and it's remained pretty much as a constant proportion, around 2%, for over a decade, even though the dollar figure has gone up. So I just reinforce that point that looking at resourcing the organisations that have been doing this work for decades in developing countries and giving a greater proportion through that program would be a very good thing. We have a particular concern that there is a constant process of review of that program and NGOs. It's been going

for pretty much the last six years. It contrasted with reviews that the government started multilateral funding, that's been a one off six months, done. The Coalition's articulated approach to charities is saying we'll be an enabler and not a controller. Could you talk a little bit about how the Coalition would help reduce the red tape and regulatory burden for NGOs in the overseas aid space?

Answer

[Gambaro] Marc, we've had these discussions before; I'm glad you brought this up. Look, it's absolutely crazy that smaller NGOs have to go through the rigorous process that larger NGOs have to go through. And there's got to be—and we talked about this for some time, I mean I've been hearing this conversation for quite a number of years, but I don't think there's anything is being done in the AusAID space.

I agree with you whole-heartedly there's too much red tape. But there's also where you have government programs and government money, there's risk attached, and there has to be some way of rolling out those types of programs. When I worked in defence, we had rigorous defence panels that would assess large defence contracts. And it was done, done, and dusted. And if people didn't meet their benchmarks, they would be penalised.

There is a constant review, and you're quite right; but I think you need to—and I just look at this from a business sense—as someone who's worked in contracting before I went into politics and then someone who worked for the government sector—we need to have benchmarks, we need to make sure that programs that are delivered, are delivered well and delivered on time and on budget.

So often in the aid space, we do throw money in that sector and we don't see any evidence or data after the program. And the thing that concerns me is how disjointed it's been. For example, I'll give the example of PNG. Someone might get a contract to deliver two-and-a-half million condoms in PNG, but there's no follow up to see if those condoms have been used, if they've been effective, if they've been delivered—Someone's having a chuckle over there—

Well, what I'm trying to say is there's no way of checking whether, you know, that particular program is delivered. And this is where we have so much fragmentation. We need to have a better coordinated approach. We also need to provide strategic focus. And I think that a lot of the NGOs and groups are telling me that they're not asked about strategic input – they're told by AusAID what they should do and that's a long way from what used to happen when we were in government. I remember going around to capital cities, when we were taking input into the white paper and regularly engaging with steering groups and committees about what our strategic approach should be. But I do agree there's too much red tape; we need to look at a way of alleviating that. Red tape's ugly in all areas.

Question

But as you know CBM Australia is an NGO that specializes in disability in developing countries, and we're really proud that Australia has become global leaders in disability-inclusive development work, as well as avoidable blindness, and I think it's important to make that distinction between avoidable blindness and disability inclusion while it's so important to have prevention of avoidable blindness program as part of our aid program but there also are lots of people whose blindness is untreatable or who's vision impairment is untreatable. And we've seen increasingly that to be effective our aid needs to address those people as well.

So I was just wondering if you can speak to your thoughts of disability within your vision of the aid policy. We currently have the "Development for All" strategy which I know you're familiar with, which is due to expire in 2014, so it would be great to have your thoughts on how disability might be represented under a Coalition government.

Answer

[Gambaro] Yeah, absolutely, it was great to see that work being crystallised, and I applaud AusAID for the work that they've done, and the steering committee and all of the work that's been done in that area. But disability is a huge part of the aid program. People with disabilities have limited access to economic development and opportunities, and we see it time and time again, in the Pacific they're ostracized and in many parts of the world, so it should feature strongly in any foreign aid program.

I can't give you any commitments on the money side of it, again, as Peter was saying, we need to see what the 10 days into the election provide for us, but it should be a strong feature of any aid development program and we'd be going in that same direction as well. Does help you answer?

Question

The Millennium Development Goals is expiring in 2015. Disability wasn't addressed in that - I wonder if you can see the Australian government in whatever form having a role of champion disability inclusion?

Answer

[Gambaro] I think that's a discussion that needs to be had, when the time comes to recommit. There are many countries that haven't met their MDGs, like, I just keep quoting PNG, but there are countries like Vietnam that are doing well. I think we need to look at all of those MDGs; how effective they are as tools and measurements and there's a lot of commitments coming out. I mentioned the Global Fund and the MDG commitments, and I know that whoever is in government will have a look at that and work with the world community, but we've always been very strong supporters, and I take your view on board that disability should be one of those MDGs.

Question

Yeah, over the last 18 months it's been privilege to chair Low Vision and Rehabilitation Committee with Vision 2020 Australia and it's been particularly encouraging to see the committee working together on engaging with government and opposition parliamentarians, federal and state, in relation to dealing with NDIS, and particularly the challenge around the aging over 65s. So today it's been reassuring once again to hear that the Coalition are all really committed to that but in light of Dr Laming's comments particularly when addressing the Keratoconus question, I would say would the research and developing an evidence base for low vision and rehabilitation and delivery and evaluation of services be a priority to the coalition…

Answer

[Gambaro] I can't even say the word; I'm going to hand over to Andrew on that one.

[Laming] Well of course good things are a priority but I can't give you specific answers. I mean around R&D we're relying on a competitive NHMRC process to do the bulk of that work so that will always be looking at the NHMRC process.

Question
[Audience member - inaudible]

Answer
[Gambaro] I think what you're saying is very, very, valid, and I think that what we need to do is have a holistic approach, because I was, I gave that other example of, you know, delivering a programme in PNG but what happens so very frequently is, there's not a holistic approach to it, there's not a health delivery model that covers all aspects of health, particularly when looking at a country like PNG and that you have fragmented programs where, clearly, some of the other aspects of health need to be addressed, and I think that what you're saying has great validity. But we need to stop throwing good money after bad, by just having these fragmented programs that don't result in long term health outcomes. So I think everything's on the table, and I know Mark hates the word 'review' but I think we need to look at better ways of delivering health and if that's working well, I'd like to, you know, like to trial or pilot it. Because nothing else has worked and, I mean, it is just so discouraging and we've raised this is at Estimates and I know Andrew does all the town with me as well with Warren Edge - we've got $20m that's being spent by AusAID on a hospital in Daru and yet we have extreme resistant TB making its way to the Torres Strait and when we look at that, when we see the photos, we want to cry. There has to be a better way of doing it.

Question
One of the things that I constantly see is the lack of integration and following on from what you said, AusAID doesn't actually pull together all the players in the field. A number of occasions that we as an NGO have actually called together all the players in a particular country, a community together and then surprise each other with the fact that we're doing some very similar things and we always invite AusAID to come and visit and be part of that and hear that too. 'Cause I think that's Australian government money that's being used and, you know, funding various things and there's other things that have been funded by private enterprises, the lack of integration, that's our biggest problem. Even with medical research, I mean, why are we spending millions on medical research in this country and other similar countries that are doing the same, why the hell aren't we doing it together?

Answer
[Gambaro] That is a very good, very, very, good suggestion Daliah, it's something that I've been looking at for quite some time. We have some of the best leading research community here. I mean, we have experts in malaria in Brisbane that have never been approached and spoken to by AusAID. We have people who are working in developing HIV, Tuberculosis, a whole lot of medical research overseas.

I think we'll have to look at how we structure it in terms of the NHMRC, in terms of what that mechanism could take the place of. Because I think, at the moment, from what I've seen, we only spend about 20 million on medical research out of the AusAID budget, and that's not much. It can make such a huge difference. But you guys do a great job. You talk to the local community, you train people, you gather up all of the interested groups, and I think that's the way it's got to be. There is a lack of strategy, and I mentioned that earlier. So often, people are dictated to, and there's no feedback or follow up.

Question

I'd like to go back to the first question, which is really in terms of accountability, oversight, and governance. And for the global work, Vision 2020, the global initiative, was set up in 1999 and adopted by Australia with the Minister of Health, Michael Wooldridge, in 2000. But it actually hadn't, didn't get a lot of teeth until the World Health Assembly this year, when, led in part by Australia's contribution they'd actually come up with some key performance indicators, which are the basis of what Jeff is saying -- that each country is meant to be looking at doing population-based surveys to gather data, and report that back to the World Health Assembly.

So that's some real accountability in that. We've been talking a lot about accountability. But if we look in 2005, when we developed the National Eye Care Framework, it was a wonderful document with really good recommendations, but absolutely no teeth. So, what happens is almost a meaningless collection of numbers, but without any goals or objectives. And equally with indigenous eye health, there's really no accountability or oversight. And so what's happened in a number of other areas -- in tobacco, and alcohol, and more recently in suicide -- there are these national principle committees that report to AHMAC.

And so, my question would be: what sort of national body, would the Coalition put in, in government, to oversee eye health in Australia, both mainstream and indigenous?

Answer

[Laming] We'd like to just see what's happening at the moment with chronic disease management oversight, because we're all in agreement, and Jen and I talked about this morning, that eye health is a critical component of that. So I think the first battle is to make sure that eye health isn't excluded from chronic disease management oversight, and then the next battle is to talk about what sort of oversight, and how much teeth that body actually has. So there's a bipartite answer here.

Of course you need that oversight - at the moment it probably isn't there and eye health isn't in the mix. And then secondly, in the end it's going to be a service delivery model on the ground that's going to need to get the results for these guys, to actually monitor and evaluate. So there's sort of a focus, both of the higher end, but also at service delivery, at your local Aboriginal community control clinic, or your local general practice, about how they're managing people with complex chronic comorbidity.

That's the new game in town, and will be for the next two decades, because no developed economy has yet worked out the best way to do it. So, two parts you've got to have the work happening on the ground to make sure the job's getting done, then you've got something to monitor and evaluate. And at that point we need to make sure that eye care and vision health is part of that monitoring.

The Hon Dr Barry Jones closing remarks

[The Hon Dr Barry Jones] Well, Andrew and Teresa I think it was a very valuable session. I regret that they had to de-ice the wings in Melbourne. Something certainly unthinkable in Brisbane. But, so we're all a bit late. But it was good to hear Mitch and Peter Dutton as well. I think so much of what's come out of the discussion confirms the all adage that the good is the enemy of the best. When you've got competing demands for limited resources and they're all valuable and you have to put it into argument in a particular way. And of course what we have

been arguing for a long time in the eye health sector, is essentially that in terms of total investment we think that the payoff is really very dramatic into the eye health area.

I mean, as Fred Hollows demonstrated so many years ago, with very modest sums you could carry out a cataract operation and the benefits were life long, where so many other diseases which are immediately live threatening, obviously the amount of expenditure involved is prodigious and the outcome is problematic. But I think it's been a very valuable discussion. I think it's… one of the encouraging things has been the way in which various NGOs and the major political parties and indeed our organisation are working together, that we are, and I think the level of interest, the level of concern, the integration into broad policy outcomes is I think is extremely valuable. And as I say I felt quite privileged to being here today, I thought the handling of the questions was excellent and in a kind of completely non-partisan way I wish you well. And I hope to think that the question of eye health from the way in which it transforms people's lives, particularly as the population ages, and with that extraordinary increase, almost exponential increase in the incidence of eye disease with additional few decades of life. It's such a very important issue, thank you very much for the work you're doing.