Community Affairs
Legislation Committee

Examination of Additional Estimates 2000-2001

Additional Information Received
VOLUME 3
Outcomes 3, 4, 5, 7, 8, 9
HEALTH AND AGED CARE PORTFOLIO

MAY 2001

Note: Where published reports, etc. have been provided in response to questions, they have not been included in the Additional Information volume in order to conserve resources. The title page of each report has been included in this document for reference purposes.

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF ADDITIONAL EXPENDITURE FOR 2000-2001

Included in this volume are answers to written and oral questions taken on notice relating to the estimates hearings on 19 and 20 February 2001

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000241

Topic: INDICATORS

Hansard page: CA 133

Senator Evans asked:

Whether or not it is appropriate to provide the same indicators used before, with caveats, pending the development of new indicators.

Answer:

Information about the entry period indicator is provided in the answer to Question E01000024. This information is provided in a format consistent with the way the Steering Committee for the Review of Commonwealth/State Service Provision now chooses to report on this indicator in the *Report on Government Services 2001*. The reasons for this are also provided in answer to Question E01000024.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000264

Topic: AGED CARE PLANNING REGIONS

Hansard Page: CA 137

Senator West asked:

It seems to me that planning regions have actually increased in size over the last six or seven years. Is that correct?

Answer:

The current Aged Care Planning Regions were established as part of the Aged Care Reforms in 1997. They were gazetted in October 1997. The size of the regions has not changed since this time.

Prior to the introduction of the *Aged Care Act 1997*, Aged Care Planning Regions were aligned to the State/Territory Government Health Regions.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000233

Topic: DAY CARE CENTRES FUNDING

Hansard Page: CA 138

Senator West asked:

How many day care centres are funded under the different programs?

Answer:

As of 30 June 2000, the numbers are as follows:

Home and Community Care	778
National Respite for Carers Program	132
Day Therapy Centres	152

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000234

Topic: WAITING TIMES - RESPITE

Hansard page: CA139

Senator West asked:

Provide the figures relating to waiting times and the issues surrounding respite.

Answer:

The Senator is referred to the answer provided to Senator Evans' Question on Notice about waiting times (QON E01000024).

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000236

Topic: 1998 ALLOCATED AND OPERATIONAL PLACES

Hansard Page: CA 141

Senator Evans asked:

How many places allocated in the 1998 round are now operational?

Answer:

As at 1 March 2001 there were 4,876 places operational of the places allocated in 1998.

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Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000237

Topic: 1999 ALLOCATION ROUND

Hansard Page: CA 141

Senator Evans asked:

How many places allocated in the 1999 round are operational?

Answer:

As at 1 March 2001 there were 4,646 places operational from the places allocated in 1999.

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HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000235

Topic: TYPE OF PLACES ALLOCATED FOR 2000 ROUND

Hansard Page: CA 134

Senator Evans asked:

Provide details on the type of places allocated.

Answer:

2000 Aged Care Approvals Round - Total New Places Allocated				
State/Territory	Residential high care places	Residential low care places	Community aged care packages (CACPs)	Totals
NSW	99	2,617	2,385	5,101
Vic	214	2,611	1,686	4,511
Qld	42	418	917	1,377
WA	26	458	566	1,050
SA	24	741	707	1,472
Tas	9	239	99	347
ACT	28	50	48	126
NT	36	30	124	190
Total	**478**	**7,164**	**6,532**	**14,174**

Note: A total of 14,174 places were allocated as above. Additional places were released in 2000 for MPS, flexible care and emergency care. These places, when added to the above, give a total of 14,777.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000054

Topic: ALLOCATION OF BEDS – FITZROY REGION

Written Question on Notice

Senator Evans asked:

Can the Department specifically explain why the Fitzroy region in Queensland was granted additional nursing home beds while a number of other regions in the State notionally had larger shortages of beds yet received no extra nursing home beds?

Answer:

In considering the targeting of new place releases, the Delegate of the Secretary of the Department of Health and Aged Care takes into account advice on identified community needs provided by the Aged Care Planning Advisory Committee in each State and Territory. Relative provision in the region is considered but consideration is also given to the needs of localities within regions.

In the 2000 Aged Care Approvals Round, 40 residential high care places were targeted to the region of Fitzroy, because of the needs of Gladstone.

This was because Gladstone is the only inland city in Queensland that does not have at least one high care aged home.

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HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000055

Topic: ALLOCATION OF BEDS – ILLAWARRA REGION

Written Question on Notice

Senator Evans asked:

Can the Department specifically explain why the Illawarra region in NSW was granted additional nursing home beds while a number of other regions in the state notionally had larger shortages of beds, based on the Government's target, but were granted fewer beds?

Answer:

In considering the targeting of new place releases, the Delegate of the Secretary of the Department of Health and Aged Care takes into account advice on identified community needs provided by the Aged Care Planning Advisory Committees in each State and Territory. Relative provision in the region is considered but consideration is also given to the needs of localities within regions.

In the 2000 Aged Care Approvals Round, 40 residential high care places were targeted for allocation to the region of Illawarra, with priority being given to the Eurobodalla SLA.

This was because the Eurobodalla SLA is under supplied for residential aged care. This area also has a high projected population growth for people aged 70 years and over.

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HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000056

Topic: ALLOCATION OF BEDS – METROPOLITAN SOUTH AND MIDLANDS REGIONS WA

Written Question on Notice

Senator Evans asked:

Can the Department specifically explain why the Metropolitan South and Midlands Regions in WA were granted no additional nursing home beds when both regions have a large notional shortage of beds when compared with the Government's target?

Answer:

In considering the targeting of new place releases, the Delegate of the Secretary of the Department of Health and Aged Care takes into account advice on identified community needs provided by the Aged Care Planning Advisory Committees in each State and Territory. Relative provision in the region is considered but consideration is also given to the needs of localities within regions.

In the 2000 Aged Care Approvals Round, 121 residential low care places and 171 Community Aged Care Packages were allocated to the Metropolitan South Region of Western Australia. Twenty residential low care places and 24 Community Aged Care Packages were allocated to the Midlands region.

While the Metropolitan South and Midlands regions were identified as having a need for residential high care places, another rural region, the South West region, was identified as having a greater need.

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HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E010000057

Topic: ALLOCATION OF BEDS-2000 ROUND

Written Question on Notice

Senator Evans asked:

Can the Department provide the allocation of places for the 2000 round in the same format as the 1999 round, ie: by provider and with nursing home and hostel beds differentiated?

Answer:

Details of the 2000 Round Approvals showing details of successful applicant, places and/or grants received and specific locations of facilities are available on the web site.

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HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000058

Topic: ALLOCATION OF BEDS

Written Question on Notice

Senator Evans asked:

Can the Department separately indicate for the years 1997, 1998 and 1999 how many allocated places have not been made operational by State, differentiating nursing home and hostel places.

Answer:

The Aged Care Act Reforms unified nursing homes and hostels into a single system of aged care homes delivering high and low care.

Residential places allocated in 1997, 1998 and 1999 that are not yet operational as at 1 April 2001

	1997 allocations		1998 allocations		1999 allocations	
	high	low	high	low	high	low
NSW	68	85	89	358	103	635
VIC*		70	65	178	109	748
QLD		80	9	172	60	298
WA				111		220
SA				5		107
TAS	1	50	5	55	6	25
ACT					3	11
NT				32	29	37

The Victorian State Government announced in its 2001/2002 Budget that it would re-open 110 high care beds which were previously closed by the State Government and held in its pool of non-operational beds.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000059

Topic: ALLOCATION OF BEDS - EXTENSIONS

Written Question on Notice

Senator Evans asked:

Can the Department separately indicate for the years 1997 and 1998 how many extensions were granted for places to be made operational.

Answer:

The Department of Health and Aged Care granted 22 extensions to providers allocated new residential aged care places in 1997 and 48 extensions to providers allocated new residential aged care places in 1998.

Seventeen (17) of the aged care homes covered by an approved extension are now operational. The Department is closely monitoring progress on the remaining 53 homes.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000061

Topic: ALLOCATION OF BEDS – OPERATIONAL PLACES

Written Question on Notice

Senator Evans asked:

The Minister has previously stated that there will be 103 aged care places per 1000 people aged 70 and over by the year 2002. Can the Department provide its latest estimate on the number of operational places per 1000 people aged 70 and over in 2002, including high care, low care and community care.

Answer:

The provision of all allocated aged care places is currently 108 places per 1,000 people aged 70 and over.

The Department of Health and Aged Care now estimates that in 2002-2003 there will be some 75,700 operating residential high care places, some 71,100 operating residential low care places and some 27,000 Community Aged Care Packages.

The Department does not estimate future provision levels of flexible care places because service development involves complex community consultations that are not amenable to detailed modelling. However, there are likely to be at least 1,500 aged care places in Multipurpose Services and Aboriginal Flexible Services.

In total, the Department estimates that in 2002-2003 there will be about 175,000 operating aged care places.

On current population projections, this is estimated to be equivalent to an operational provision level of just over 100 places per 1,000 people aged 70 and over.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000060

Topic: AGED CARE PLANNING – REVIEW OF PLANNING PROCESS

Hansard Page: CA 6

Senator Evans asked:

(a) In terms of the review of planning process, what has occurred and when is the review due to be completed?

(b) What consultation has occurred in relation to the review?

Answer:

(a) The Review is:

1. Examining planning process to improve rural outcomes in aged care. This includes:
   - better considering need at a sub-regional level;
   - considering cross-border issues for planning; and
   - better linking small, rural communities to aged care.

   A trial is now underway in seven rural regions to work with local stakeholders to develop new residential care homes;

2. Assessing the current distribution and amount of viability funding to distribute extra viability funding for small, rural, and especially remote aged care homes; and

3. Improving information on rural aged care by:
   - developing case studies of good rural care; and
   - examining Australian and international research on rural aged care.

The Review is a four year initiative expected to be complete by July 2003.

(b) The review has provided information to the Aged Care Working Group and to Commonwealth and State officials. A seminar has been conducted, to inform consumers, service providers, managers and academics about the Rural Review, and to receive feedback. Consultations have also occurred with peak bodies in aged care about good examples of rural aged care.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000238

Topic: 1998-1999 SURRENDERED LICENSES

Hansard Page: CA 141

Senator Evans asked:

How many licenses have been surrendered for the 1998-1999 round?

Answer:

117 residential care places allocated in 1998 and 105 residential care places allocated in 1999 have been surrendered and either have been reallocated, or are in the process of reallocation.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000239

Topic: ALLOCATIONS IN THE NORTHERN TERRITORY

Hansard Page: CA 142

Senator Evans asked:

(a) Provide information on who got licences in the 1999 allocation round in the NT.

(b) What other places have now become operational and whether any places are subject to extensions of the deadline in the NT?

Answer:

(a) The following providers were allocated places in the Northern Territory in the 1999 Aged Care Approvals Round:

- Australian Red Cross Katherine Centre - 4 Community Aged Care Packages;
- Jawoyn Association - 8 Community Aged Care Packages;
- Northern Territory Association for Mental Health - 7 Community Aged Care Packages;
- Moran Health Care Group (Victoria) Pty Ltd - 29 Residential High Care and 37 Residential Low Care; and
- Urapuntja Health Service – 5 Community Aged Care Packages.

(b) None of the 66 new residential aged care places allocated to the Northern Territory in the 1999 Aged Care Approvals Round are operational.

No applications for extension of the 1999 allocations have been received. Approved Providers who received Provisional Allocations from the 1999 Aged Care Approvals Round have until 1 November 2001 to make the places operational or apply for an extension.

All 24 Community Aged Care Packages allocated in the Northern Territory in the 1999 Approvals Round are operational.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000265

Topic: CAPITAL GRANTS FOR CONSTRUCTION

Hansard Page: CA 142

Senator Evans asked:

Dr Graham, you have said you are not able to tell us who applied for capital grants for construction. You are only able to publish who got them. Is that correct?

Answer:

The Department's legal advice is that disclosure of information about unsuccessful applications for capital grants under the *Aged Care Act 1997* come within the protected information provisions of the Act. In regard to information about unsuccessful applications for capital funding made other than under the Act, both the Department and the applicant would normally regard all applications as having been made in confidence, and it is Departmental practice to treat such information about unsuccessful applications accordingly.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000240

Topic: PLACES ALLOCATED TO PRIMELIFE

Hansard Page: CA 143

Senator Evans asked:

Provide details about the number of places in the last three rounds allocated to Primelife for both residential and community care.

Answer:

Primelife Corporation Ltd was not allocated places in the 1999 Approvals Round or the 1998 Approvals Round.

Primelife Corporation Ltd was allocated 293 residential low care places for six aged care homes in the 2000 Aged Care Approvals Round.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000068

Written Question on Notice

Topic: AGED CARE PLACES IN REGIONAL HEALTH SERVICE CENTRES (RHSC)

Senator Evans asked:

In the 1999-00 RHSC budget initiative, 100 new aged care places were to be allocated during 2000-01 (Ref: DHAC Annual Report p. 311). Have the 100 aged care places been allocated? Please detail location of places and the basis of the planning/allocation decisions.

Answer:

In March 2000, 14,777 aged care places were released for allocation. Of these 285 were for Mutlipurpose Services which included the 100 places from the 1999-00 RHSC budget initiative.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000242

Topic: TWO YEAR REVIEW OF AGED CARE REFORMS

Hansard Page: CA 155

Senator Evans asked:

The overall contract cost for Professor Gray for the Two Year Review.

Answer:

The overall contract cost for Professor Gray will be a maximum of $133,500 (including GST).

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000243

Topic: EVALUATION OF AGED CARE AT HOME PILOTS

Hansard Page: CA 158

Senator Evans asked:

The Senator has expressed an interest in seeing a copy of the aged care at home pilot if it is to be a public document.

Answer:

The Extended Aged Care at Home (EACH) evaluation is still ongoing.

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Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000260

Topic: FOOD QUANTITY AND QUALITY COMPLAINTS

Hansard Page: CA 164

Senator Evans asked:

Did the State Manager of the Victorian State Office consult with the Central Office before referring Complaints to the Agency?

Answer:

No

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000261

Topic: NATIONAL STRATEGY FOR AN AGEING AUSTRALIA

Hansard Page: CA 157

Senator Evans asked:

All right then, there is an expert group that has been appointed. When were they appointed?

Answer:

The expert group for the National Strategy for an Ageing Australia was appointed on the 30th August 2000.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000267

Topic: HEALTHY AGEING RESEARCH REPORT

Hansard Page: CA 157

Senator Evans asked:

Copy of report by University of Sydney to review healthy ageing research on behalf of working group under Community Service Minister's Advisory Council.

Answer:

This report is currently under review.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000268

Topic: SAFE AT HOME TRIAL

Hansard Page: CA 158

Senator Evans asked:

Copy of evaluation of Safe at Home trial - whether report to be made publicly available.

Answer:

The report is currently under review.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000270

Topic: EXPENDITURE FIGURES ON RESPITE

Hansard Page: CA 161

Senator Evans asked:

Please provide total expenditure on respite under each program for 99-00.

Answer:

The total estimated expenditure on Residential Aged Care Respite for the 1999-2000 financial year was $75 million and on the National Respite for Carers program $44 million. The total estimated HACC funding allocated to respite services in 1999-2000 was $111.1 million, of which the Commonwealth contributed some $66.7 million.

This shows the Commonwealth contributed $185.7 million on respite.

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Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000069

Topic: RESPITE CARE - GENERAL

Written Question on Notice

Senator Evans asked:

The Commonwealth funds a range of respite services through three major programs: 1) residential aged care respite, 2) HACC, and 3) National Respite for Carers Program (NRCP)

(a) Please provide total Commonwealth expenditure on respite under each program for 99-00 and forward estimates through to 2003-04.

(b) What other Commonwealth funds are available for respite services eg as part of funding for CACPs and EACH packages and under the Commonwealth State Disability Agreement?

Answer:

(a) Total estimated HACC funding allocated to respite services in 1999-2000 was $111.1 million, of which the Commonwealth contributed some $66.7 million.
There is an annual HACC plan prepared by States for Commonwealth approval.

The forward estimates are indexed by a cocktail mix of movements in the CPI and Safety Net Adjustment decisions made by the Australian Industrial Relations Commission. The index is known as a Wage Cost Index and is consistent with whole of Government indexation arrangements introduced in 1995-96. The Wage Cost Index is used in indexing forward estimates and incorporates the Government's forecasts of movements in wages and prices and as such is classified material.

The wage cost index was introduced and used by the previous Labor Government and remains in use.

(b) Commonwealth funding is provided for respite under a range of other programs including CACPs, EACH packages, day therapy centres. Because each of these arrangements are individually tailored to suit the clients no specific funding can be attributed directly to the respite component.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000070

Topic: RESIDENTIAL RESPITE

Written Question on Notice

Senator Evans asked:

(a) What is the current actual ratio for residential respite per 1000 70+ at the national, state and aged care planning region level?

(b) How many respite beds were allocated by the Minister in the 1999 and 2000 rounds? Please provide breakdown by high care and low care and aged care planning region.

(c) What is the utilisation rate of residential respite per 1000 70+

(d) What impact have Carer Respite Centres had on improving referral to and take-up of residential respite?

Answer:

(a) The current availability of residential respite days to aged care homes is equivalent to 2.6 places for every one thousand people aged 70 years or over. The equivalent figures for each state and each aged care planning region are given in the Commonwealth Department of Health and Aged Care Annual Report 1999-2000, pages 315 to 317.

(b) The Minister does not allocate respite beds in the annual allocation rounds.

(b) The utilisation rate of residential respite days in 1999-2000 was equivalent to 1.6 places for every 1000 people aged 70 or over.

(d) The role of Carer Respite Centres is to assist people to obtain the form of respite care most suited to their needs. This may be in-home respite, community respite or residential respite. Many older people, and their carers, have a preference for in-home or community respite. However, since carer respite centres were first established in 1996-97, residential respite use has increased from approximately 870,000 days annually to about 990,000 days annually.

In response to Recommendation 3 of the Two Year Review (Gray Report) it was recently announced that $7m has been directed to Carer Respite Centres to improve access to flexible residential respite.

$4m has been earmarked for Carer Respite Centres across the country to enable them to directly reserve and purchase residential respite places on behalf of carers.

$3m has been allocated to expand respite services available in the community including residential respite, in-home respite, day centre respite, and host family and peer support respite.

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000071

Topic: RESIDENTIAL RESPITE

Written Question on Notice

Senator Evans asked:

(a) Following the 1996 AIHW Respite Review. The Committee was told that the Department would introduce from October 1997 a number of measures to "boost take-up of respite care bed days, including financial and administrative measures and demand management" (answer to Estimates QON, June 1999). What were these measures and their effect? What evaluative work has been done?

(b) What is the average length of stay for each respite admission (both high care and low care)?

(c) What proportion of respite residents become permanent residents at the same facility (both high care and low care)?

(d) What is the current rate of respite subsidy for both high care and low care facilities? Please distinguish between basic respite care subsidy, respite care subsidy (taking into account all 3 components) for a high care and low care resident?

Answer:

(a) The 1996 Respite Review was carried out by this Department not AIHW. AIHW carried out one of several commissioned studies for the Review.

The Government has greatly extended the range of respite care available. The National Respite for Carers Program has grown from $19 million in 1996-97 to more than $63 million this year. This program funds a diverse range of respite services, including 82 Carer Respite Centres that are able to purchase or arrange respite care appropriate to people's needs.

Residential respite care is targeted towards those people who need it by requiring people using residential respite care to have a specific approval from an aged care assessment team (ACAT).

Residential respite care is financially and administratively more attractive to both user and provider for the following reasons:

- Unlike longer-term residents, users of residential respite do not have to undergo an income and assets test.
- Also unlike longer-term residents, users of residential respite do not have to pay an accommodation charge or bond.
- Respite residents of aged care homes only have to pay the basic pensioner daily fee (up to $23) whether or not they are pensioners.
- To make respite care attractive to service providers, the Commonwealth pays them a daily supplement (as well as the standard daily subsidy) for respite residents.
- The Commonwealth also pays providers the pensioner supplement for all respite residents whether or not they are pensioners.
- Providers do not have to assess respite residents against the Resident Classification Scale (RCS) to obtain the Commonwealth subsidy.

Residential respite use has grown from 870,000 days annually in 1996-97 to the current level of some 990,000 days annually.

(b) About 21 days for both high care and low care.

(c) Around one in seven of both high care and low care respite residents.

(d) (i) Respite subsidies for high level care are paid at the RCS Level 3 and for low care at Level 6.
(ii) In addition a respite supplement for high level care of $28.34 is paid and $17.85 for low level care.
(iii) Also paid is a pensioner supplement of $5.56
(iv) Respite supplements are for Certified Services only. Non-certified services respite supplements are $22.57 (high level) and $12.07 (low level).
(v) Oxygen and enteral supplements may also be payable for some respite residents.

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Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000072

Topic: RESIDENTIAL RESPITE

Written Question on Notice

Senator Evans asked:

(a) What is the current average waiting time for a person assessed by an ACAT as needing residential respite and them accessing a bed?

(b) What proportion are placed within
- **(i) 14 days**
- **(ii) 3 months**
- **(iii) 6 months**

Answer:

The Senator is referred to the answer provided to his earlier Question on Notice (E01000024).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000073

Topic: RESIDENTIAL RESPITE

Senator Evans asked:

(a) For both high care and low care facilities could we have the following data:

- **Respite bed days as a proportion of total bed days**
- **Utilisation rate of approved respite bed days**
- **Occupation rate of the total bed days.**

(b) How many facilities were approved to provide residential respite in

99-00 and how many actually provided it? Please provide a breakdown of the number of facilities providing respite care days in 20 day bands eg how many facilities provided between 1 and 20 respite bed days?

(c) For each aged care planning region in 99-00 please provide the number of respite beds allocated and the utilisation rate in aggregate and by type of provider.

(d) For each state in 99-00 please supply the total number of respite care days used (level and as a proportion per person 70+) by capital. Other metropolitan, rural, remote and in aggregate.

Answer:

(a) The information is as follows:

APPROVED RESPITE BED DAYS AS A PROPORTION OF ALL BED DAYS 1999-2000

CARE TYPE	TOTAL BED DAYS	RESPITE BED DAYS	PROPORTION
HIGH LEVEL	26,397,530	676,011	2.56%
LOW LEVEL	23,127,495	805,130	3.48%
NEW	2,159,340	75,137	3.48%
TOTAL	51,684,365	1,556,278	3.01%

Note: The respite bed days figure is the total annual allocation of approved respite days to aged care homes.

UTILISATION RATE OF APPROVED RESPITE BED DAYS
1999-2000

HOME TYPE	APPROVED RESPITE BED DAYS	RESPITE BED DAYS USED	UTILISATION RATE
HIGH CARE	676,011	339,672	50.25%
LOW CARE	805,130	599,044	74.40%
NEW	75,137	54,142	72.06%
TOTAL	1,556,278	992,858	63.80%

OCCUPATION RATE OF TOTAL AVAILABLE RESIDENTIAL BED DAYS
1999-2000

HOME TYPE	RATE
HIGH CARE	97.15%
LOW CARE	94.69%
NEW	89.01%
ALL	95.56%

Note: these figures give the occupancy rate of residential aged care places by both permanent and respite residents.

(b) The information is as follows:

Over 2,200 aged care homes were approved to provide residential respite care in 1999-2000. 2,088 homes provided it.

NUMBER OF HOMES PROVIDING RESPITE: 20-DAY INTERVALS

Days	***Homes***	*Days*	***Homes***	*Days*	***Homes***
1-20	55	**761-780**	27	**1601-1620**	1
21-40	41	**781-800**	17	**1621-1640**	1
41-60	44	**801-820**	18	**1641-1660**	1
61-80	43	**821-840**	12	**1681-1700**	2
81-100	33	**841-860**	6	**1701-1720**	3
101-120	44	**861-880**	7	**1721-1740**	1
121-140	42	**881-900**	13	**1741-1760**	1
141-160	47	**901-920**	7	**1781-1800**	1
161-180	37	**921-940**	6	**1801-1820**	3
181-200	34	**941-960**	11	**1841-1860**	1
201-220	43	**961-980**	10	**1861-1880**	1
221-240	47	**981-1000**	5	**1881-1900**	1
241-260	62	**1001-1020**	4	**1921-1940**	1
261-280	69	**1021-1040**	3	**2001-2020**	1
281-300	97	**1041-1060**	5	**2041-2060**	2
301-320	93	**1061-1080**	10	**2061-2080**	2
321-340	121	**1081-1100**	7	**2301-2320**	1
341-360	105	**1101-1120**	2	**2461-2480**	1
361-380	94	**1121-1140**	5	**2641-2660**	1

381-400	55	**1141-1160**	5	**2781-2800**	1
401-420	55	**1161-1180**	2	**2841-2860**	1
421-440	48	**1181-1200**	5	**2881-2900**	1
441-460	30	**1201-1220**	2	**3101-3120**	1
461-480	32	**1221-1240**	4	**3321-3340**	1
481-500	16	**1241-1260**	3	**3341-3360**	1
501-520	24	**1261-1280**	3	**3421-3440**	1
521-540	27	**1281-1300**	2	**3661-3680**	1
541-560	33	**1301-1320**	6	**3801-3820**	1
561-580	28	**1321-1340**	3	**3901-3920**	1
581-600	39	**1341-1360**	4	**4201-4220**	1
601-620	36	**1381-1400**	2	**4961-4980**	1
621-640	34	**1401-1420**	2	**5481-5500**	1
641-660	39	**1441-1460**	1	**6241-6260**	1
661-680	44	**1461-1480**	1	**6481-6500**	1
681-700	39	**1501-1520**	1	**6761-6780**	1
701-720	25	**1541-1560**	3	**7321-7340**	1
721-740	32	**1561-1580**	1	**7961-7980**	1
741-760	31	**1581-1600**	1		

(c) The Commonwealth does not approve or allocate respite beds; it approves allocations of respite days. An allocation of 365 respite days is the equivalent of a respite place. The 1999-2000 allocation of respite days expressed as respite place equivalents by region is given in the Department's Annual Report for 1999-2000

(d) RESPITE DAYS USED BY LOCALITY AND STATE

State	High or Low Level	Capital	Other Metro	Remote	Rural	Grand Total
ACT	H	3419				3419
	L	9232				9232
ACT Total		12651				12651
NSW	H	117006	27716	675	31707	177104
	L	111124	32627	2606	63145	209502
NSW Total		228130	60343	3281	94852	386606
NT	H	1456		2557		4013
	L	585		1561		2146
NT Total		2041		4118		6159
QLD	H	34671	10737	1218	24123	70749
	L	43602	15899	3122	41359	103982
QLD Total		78273	26636	4340	65482	174731

State	High or Low Level	Capital	Other Metro	Remote	Rural	Grand Total
SA	H	31973		7	5842	37822
	L	46941		199	14997	62137
SA Total		78914		206	20839	99959
TAS	H	3089		238	7307	10634
	L	7514		46	10607	18167
TAS Total		10603		284	17914	28801
VIC	H	37940	2941		19245	60126
	L	81073	4838		49590	135501
VIC Total		119013	7779		68835	195627
WA	H	15833		2050	5731	23614
	L	48140		4426	12144	64710
WA Total		63973		6476	17875	88324
Australia		593598	94758	18705	285797	992858

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000074

Topic: HACC RESPITE – COMMONWEALTH FUNDING

Written Question on Notice

Senator Evans asked:

What Commonwealth funding was allocated to the provision of respite services under the HACC program in 99-00 and forward estimates through to 2003-04?

Answer:

Total estimated HACC funding allocated to respite services in 1999-2000 was $111.105 million, of which the Commonwealth contributed some $66.663 million.

There are no forward estimates for respite care expenditure in HACC.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000075

Topic: HACC RESPITE – UNIT COST

Written Question on Notice

Senator Evans asked:

What is the unit cost for respite services under the HACC program by state and by type of respite?

Answer:

The Commonwealth has not yet received a full set of business reports from the States under the Amending HACC Agreement, so the actual cost of respite is not available.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000076

Topic: HACC RESPITE

Written Question on Notice

Senator Evans asked:

How many clients received access to respite under the HACC program by type of respite (eg in-home, centre-based) in 99-00?

Answer:

This information is not available.

An estimated 4.6 million hours of respite care was provided under the HACC Program in 1999-2000.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000077

Topic: NATIONAL RESPITE FOR CARERS PROGRAM (NRCP)

Written Question on Notice

Senator Evans asked:

(a) What initiatives are funded under the NRC Program. For that component of NRCP which provides respite services, does the Commonwealth simply act as a purchaser and where does it purchase respite from (eg HACC providers)?

(b) Please supply total expenditure on NRCP for each year since 1997-98 and forward estimates through to 2003-04. Please provide data by state and component, that is expenditure on respite services, Carer Respite Centres and Carer Resource Centres for each state.

Answer:

(a) The initiatives under the NRCP include:

1) Carer Respite Centres
2) Carer Resource Centres
3) Respite Services
4) National projects in carer training and education

Carer Respite Centres do not usually provide direct respite services but purchase or arrange respite from a range of service providers including private nursing services, day care centres, Home and Community Care (HACC) providers or residential aged care homes.

Respite Services funded by the Commonwealth under the NRCP provide specific respite services for carers of people with dementia and challenging behaviour, the frail aged and younger people with a disability.

(b)

State	Component	1997/1998	1998/1999	1999/2000
NSW	**Respite Services**	5,048,375	5,562,974	7,831,651
	Respite Centres	2,819,443	4,004,118	6,453,843
	Resource Centres	108,333	101,625	207,214
	Total	**7,976,151**	**9,668,717**	**14,492,708**
VIC	**Respite Services**	3,264,000	4,549,615	5,042,664
	Respite Centres	1,927,500	2,788,630	4,596,169
	Resource Centres	133,000	134,995	240,325
	Total	**5,324,500**	**7,473,240**	**9,879,158**

QLD	**Respite Services**	2,181,987	2,937,060	3,382,207
	Respite Centres	1,474,118	2,656,499	3,678,828
	Resource Centres	57,870	68,225	103,387
	Total	**3,713,975**	**5,661,784**	**7,164,422**
SA	**Respite Services**	1,284,137	1,743,734	1,953,438
	Respite Centres	831,752	1,216,441	1,960,525
	Resource Centres	91,300	100,393	134,012
	Total	**2,207,189**	**3,060,568**	**4,047,975**
WA	**Respite Services**	1,158,965	1,352,591	1,679,221
	Respite Centres	680,583	1,104,585	1,860,988
	Resource Centres	90,000	91,350	105,069
	Total	**1,929,548**	**2,548,526**	**3,645,278**
TAS	**Respite Services**	603,107	690,801	930,875
	Respite Centres	458,000	628,649	1,083,375
	Resource Centres	90,000	91,350	122,122
	Total	**1,151,107**	**1,410,800**	**2,136,372**
ACT	**Respite Services**	166,429	306,256	436,116
	Respite Centres	171,000	273,680	392,641
	Resource Centres	92,200	101,420	110,272
	Total	**429,629**	**681,356**	**939,029**
NT	**Respite Services**	149,077	228,473	296,694
	Respite Centres	587,993	707,930	770,758
	Resource Centres	90,000	98,963	124,076
	Total	**827,070**	**1,035,366**	**1,191,528**
TOTAL Respite Services		**13,856,077**	**17,371,504**	**21,552,866**
TOTAL Respite Centres		**8,950,389**	**13,380,532**	**20,797,127**
TOTAL Resource Centres		**752,703**	**788,321**	**1,146,477**
National Support & Projects[(1)]		**70,405**	**70,691**	**465,821**
GRAND TOTAL		**23,629,574**	**31,611,048**	**43,962,291**

(1) National support & projects expenditure comprises the National Dementia Behavioural Advisory Service, promotional activities, a national respite and resource centre workshop and operational costs for resource centres.

NRCP Forward Allocation 2001- 2004

The forward estimates are indexed by a mix of movements in the CPI and Safety Net Adjustment decisions made by the Australian Industrial Relations Commission. The index is known as a Wage Cost Index and is consistent with whole of Government indexation arrangements introduced in 1995-96 by the former Labor Government. The Wage Cost Index used in indexing forward estimates incorporates the Government's forecasts of movements in wages and prices and as such is classified material.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000078

Topic: RESPITE SERVICES FOR PEOPLE WITH DEMENTIA AND/OR CHALLENGING BEHAVIOURS

Written Question on Notice

Senator Evans asked:

In the 99-00 Budget $82.2m over 4 years was allocated under the NRCP for increasing access to respite care for carers of people with dementia or challenging behaviours

(a) What research was used to identify this group as one whose respite needs were not met under current programs? Were any other groups identified? if so, what specific initiatives have been developed to cater for their requirements?

(b) What was actual spending in 1999-00?

(c) Of the annual allocation, what is the breakdown of expenditure on 1) Respite services 2) Carer Respite Centre expansion 3) Other?

(d) How will funds be allocated between and within states? If the allocation is needs based, what data will be used to determine need?

(e) Given the specialised care needs of this target group what work has been done to establish that an appropriately skilled workforce is available to meet the program's objectives?

(f) What will be the fees policy for this initiative?

Answer:

(a) A number of research studies were commissioned as part of the 1996 Respite Review. These are summarised in "The Respite Review Report" 1996, published by the Department. Carers of people with dementia or challenging behaviour were specifically identified in "Review of Respite Care Services provided in the Community" by Dr Rhys Hearn and others, 1996.

(b) $5,230,011 in 1999-2000

(c) The funds were allocated over a four year period 1999-2000 to 2003-2004

All figures presented with Indexation

New Dementia Services	Carer Respite Centres	Enhancement of Respite Service Quality	Implementation Funds	Total
$56.3M	$15.2M	$6.3M	$4.4M	**$82.2M**

(d) The funds are allocated between State/Territories based on HACC target population estimates. (Rural and Remote areas were given a higher priority because of limited access to and reduced availability of appropriate services and skilled personnel.)

Allocation within States/territories is based on a set criteria including; relevant experience and expertise, quality and clarity of the proposal, expected benefits, innovation, flexibility of services, the capacity of the proposed service to meet the needs of specified priority target groups and value for money.

(e) Funding under the initiative also includes the two projects specifically targeted at Carer Education and Training. They are the Carer Education and Workforce Training Project and the National Dementia Behaviour Advisory Service.

(f) The Government does not prescribe fees for this initiative.
The Carer Respite Centre guidelines indicate carers may pay fees, contributions or donations for services provided subject to income test criteria applied by the organisation. No member of the target population would be refused access to appropriate services due to an inability to contribute to the cost of those services.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000079

Topic: CARER RESPITE CENTRES (CRCS)

Written Question on Notice

Senator Evans asked:

(a) What level of brokerage funding is available to CRCs to assist carers' meet emergency, unplanned or short-term needs where such needs cannot otherwise be met?

(b) What brokerage money was spent in 99-00 and how many clients were assisted?

(c) What do we know about the group assisted in terms of location, reason that no other respite options were available, characteristics of person they are caring for?

(d) What sort of respite services were provided with brokerage money?

(e) Carer Respite Centres involves coordination of respite services not actual provision. What data is collected to follow-up whether carers are able to access respite following a referral by the CRC?

(f) What evaluation has been done of the performance and effectiveness of CRCs?

(g) How are performance outcomes measured?

(h) Could you please provide a list of the locations of CRCs?

Answer:

(a) $8,193,106 in 2000-2001.

(b) $6,958,978 of brokerage funding was spent by the Carer Respite Centres in 1999-2000 to assist 24,864 carers to purchase respite care in the same year.

(c) Carer Respite Centres collect relevant information about the carers to individually tailor services to suit their needs. Specific information relating to the groups is not available.

(d)
- In-home respite
- Host Family Respite
- Residential Respite
- Community Day Centre Respite

(e) See (c) above.
When Carer Respite Centres make referrals they ensure that an appropriate service is organised. Some carers, however, prefer to make their own respite arrangements based upon the information provided by the Centre staff.

(f) The performance and effectiveness of Carer Respite Centres is gauged by the quarterly reports provided to the Department.

(g) Outcomes are based on:
- the number of carers that contact the Centre for assistance,
- the growth in carer contacts, especially new carers,
- compliance with funding agreements.

(h) See Attachment 1. List of Carer Respite Centre and locations.

Question: E01000079

Attachment 1

REGION	STATE	CENTRE NAME	STREET ADDRESS	LOCALITY	P/C
ACT Region	ACT	ACT Carer Respite Centre	2 Minns Place	WESTON	2611
Central Coast Region	NSW	Central Coast Carer Respite Centre	Cnr Holden & Racecourse Roads	GOSFORD	2250
Central West Region	NSW	Central West Carer Respite Centre	120 Hill Street	ORANGE	2800
Cumberland / Prospect Region	NSW	Cumberland / Prospect Carer Respite Centre	3 Homelands Avenue	CARLINGFORD	2118
Far North Coast Region	NSW	Far North Coast Carer Respite Centre	3/106 Main Street	ALSTONVILLE	2477
Hunter Region	NSW	Hunter Carer Respite Centre	Booth Wing, Longworth Ave.	WALLSEND	2287
Hunter Region	NSW	Hunter Carer Respite Centre – Muswellbrook Office	c/- Maitland Shire Council, Maitland Street	MUSWELLBROOK	2333
Illawarra Region	NSW	Illawarra Carer Respite Centre	Upstairs 7 Railway Parade	KIAMA	2533
Inner West Region	NSW	Inner West Carer Respite Centre	Ward 31, Concord Hospital, Hospital Road	CONCORD	2139
Mid North Coast Region	NSW	Mid North Coast Carer Respite Centre	23 Wallace Street	MACKSVILLE	2447
Mid North Coast Region	NSW	Taree Carer Respite Centre	Business Enterprise Centre, 140A Victoria Street	TAREE	2430
Nepean Region	NSW	Nepean Carer Respite Centre	20 Westminster Street	ROOTY HILL	2770
New England Region	NSW	New England Carer Respite Centre	188 Peel Street	TAMWORTH	2340
Northern Sydney Region	NSW	Northern Sydney Carer Respite Centre	Suite 1, Level 1, 3-5 Bryson Street	CHATSWOOD	2067
Orana Region	NSW	Orana Carer Respite Centre	Cobbora Road	DUBBO	2830
Far West Region	NSW	Far West Carer Respite Centre	HACC Centre, Broken Hill City Council,	BROKEN HILL	2880
Riverina / Murray Region W Sector	NSW	Deniliquin Carer Respite Centre	133 End Street	DENILIQUIN	2710
Riverina / Murray Region E Sector	NSW	Wagga Wagga Carer Respite Centre	Shop 17, Fitzmaurice Street	WAGGA WAGGA	2650
South East Sydney Region	NSW	South East Sydney Carer Respite Centre	20 Harrow Road	BEXLEY	2207

South West Sydney Region	NSW	South West Sydney Carer Respite Centre	Campbell Street	LIVERPOOL	2170
Southern Highlands Region	NSW	Southern Highlands Carer Respite Centre	257 Crawford Street	QUEANBEYAN	2620
Central Region	NT	Central Region Carer Respite Centre	446 South Stuart Hwy Alice Springs NT	ALICE SPRINGS	0870
Cross Border Region	NT, SA, WA	Central Australia Cross Border Respite Centre	3 Wilkinson Street	ALICE SPRINGS	0870
East Arnhem Region	NT	East Arnhem Carer Respite Centre	Endeavour House, Endeavour Square	NHULUNBUY	0880
Northern Region	NT	Northern Region Carer Respite Centre	Unit 17, Winngate Centre, Stuart Highway	WINNELLIE	0820
Brisbane North Region	QLD	Brisbane North Carer Respite Centre	236 Stafford Road	STAFFORD	4053
Brisbane South Region	QLD	Brisbane South Carer Respite Centre	972 Logan Road	HOLLAND PARK	4122
Central Region	QLD	Central Carer Respite Centre	16 Blanchard Street	NORTH ROCKHAMPTON	4701
Central West Region	QLD	Central West Carer Respite Centre	106 Galah Street	LONGREACH	4730
Darling Downs Region	QLD	Darling Downs Carer Respite Centre	Stenner Street	TOOWOOMBA	4350
Far North Queensland Region	QLD	Far North Queensland Carer Respite Centre	21 Birch Street	MANUNDA	4870
Mackay Region	QLD	Mackay Carer Respite Centre	99 Evans Street	MACKAY	4740
Northern Region	QLD	Northern Carer Respite Centre	55 Mooney Street	GULLIVER	4812
South Coast Region	QLD	South Coast Carer Respite Centre	52 Davenport Street	SOUTHPORT	4215
South Coast Region	QLD	South Coast Carer Respite Centre – Beaudesert Office	113 Brisbane street	BEAUDESERT	4285
South West Region	QLD	South West Carer Respite Centre	145 Alfred Street	CHARLEVILLE	4470
Sunshine Coast Region	QLD	Sunshine Coast Carer Respite Centre	22 Evans Street	MAROOCHYDORE	4558
Sunshine Coast Region	QLD	Caboolture Carer Respite Centre	12 King Street	CABOOLTURE	4510
West Morton Region	QLD	West Morton Carer Respite Centre	27 Ellenborough Street	IPSWICH	4305
Wide Bay Region	QLD	North Wide Bay Carer Respite Centre	Shop 7, Bonalea Arcade, 62 Woongarra Street	BUNDABERG	4670
Wide Bay Region	QLD	South Wide Bay Carer Respite Centre	Shop 7, Bonalea Arcade, 62 Woongarra Street	MARYBOROUGH	4650

North & West Country Region	SA	North & West Country Carer Respite Centre	10 Pitt Street	ADELAIDE	5000
North & West Country Region	SA	North &West Country Carer Respite Centre - Barossa	26 Second Street	NURIOOTPA	5355
North & West Country Region	SA	North & West Country Carer Respite Centre - Lower North		CLARE	
North & West Country Region	SA	North & West Country Carer Respite Centre - Yrk Pen	C/- N Yorke Peninsula R/Health Service,	WALLAROO	5556
North & West Metropolitan Region	SA	North & West Metropolitan Carer Respite Centre	77 Gibson Street	BOWDEN	5007
South & East Country Region	SA	Southern Country Carer Respite Centre	4 Third Street	MURRAY BRIDGE	5253
South & East Country Region	SA	South East Carer Respite Centre	6 Davenport Street	MILLICENT	5280
South & East Metropolitan Region	SA	South & East Metropolitan Carer Respite Centre	1389 South Road	BEDFORD PARK	5042
North Region	TAS	North Carer Respite Centre	22 Earl Street	LAUNCESTON	7250
North Region	TAS	North Carer Respite Centre - St Helens Office	St Helens Hospital, Circassion Street	ST HELENS	7216
North West Region	TAS	North West Carer Respite Centre	14 Cattley Street	BURNIE	7320
South Region	TAS	South Carer Respite Centre	11 Clare Street	NEW TOWN	7008
South Region	TAS	South Carer Respite Centre - Huon Valley Office	Huon Valley Health Centre, 85 Main road	HUONVILLE	7190
South Region	TAS	South Carer Respite Centre - East Coast Office	Spring Bay Community & Health Centre,	TRIABUNNA	7190
Barwon Region	VIC	Barwon Carer Respite Centre (inc. Warrnambool)	40 Little Fyans street	GEELONG	3220
Eastern Metropolitan Region	VIC	Eastern Metropolitan Carer Respite Centre - Inner East	13 Fenhurst Grove	KEW	3101
Eastern Metropolitan Region	VIC	Eastern Metropolitan Carer Respite Centre - Outer East	355 Stud Road	WANTIRNA SOUTH	3152
Gippsland Region	VIC	Gippsland Carer Respite Centre	Cnr Princes Highway & Seymour Street	TRARALGON	3844
Grampians Region	VIC	Grampians Carer Respite Centre	115 Ascot Street	BALLARAT SOUTH	3350
Hume Region	VIC	Hume Carer Respite Centre	91A Wyndham Street	SHEPPARTON	3630
Loddon Mallee Region	VIC	Loddon Mallee Carer Respite Centre	Anne Caudle Centre, Barnard Street	BENDIGO	3550
Northern Metropolitan Region	VIC	Northern Metropolitan Carer Respite Centre - North East	585 Gilbert Road	WEST PRESTON	3072

Northern Metropolitan Region	VIC	Northern Metropolitan Carer Respite Centre - North West	88 Justin Avenue	GLENROY	3072
Southern Metropolitan Region	VIC	Southern Metropolitan Carer Respite Centre - Inner South	260-294 Kooyong Road	CAULFIELD	3162
Southern Metropolitan Region	VIC	Southern Metropolitan Carer Respite Centre - Outer South	Kingston Centre, Warrigal Road	CHELTENHAM	3192
Southern Metropolitan Region	VIC	Southern Metropolitan Carer Respite Centre - Peninsula	Mount Eliza Centre, Jacksons Road	MT ELIZA	3930
Western Metropolitan Region	VIC	Western Metropolitan Carer Respite Centre - Inner West	576 Barkly Street	FOOTSCRAY WEST	3012
Western Metropolitan Region	VIC	Western Metropolitan Carer Respite Centre - Outer West	176-190 Furlong Road	ST ALBANS	3021
Central Wheatbelt Region	WA	Central Wheatbelt Carer Respite Centre	88 Wellington Street	NORTHAM	6401
Goldfields Region	WA	Esperance Carer Respite Centre	Forrest Street	ESPERANCE	6450
Goldfields Region	WA	Kalgoorlie Carer Respite Centre	39 Dugan Street	KALGOORLIE	6430
Great Southern Region	WA	Great Southern Carer Respite Centre	Hardie Road	ALBANY	6330
Kimberley Region	WA	Kimberley Carer Respite Centre	90 Herbert Street	BROOME	6725
Midwest Region	WA	Midwest Carer Respite Centre	Shenton Street	GERALDTON	6530
Perth (East, North & South Metro)	WA	Perth Carer Respite Centre	110 Goderich Street	PERTH	6004
Perth (East, North & South Metro)	WA	Perth Carer Respite Centre – Fremantle Office	Shop 22, William Street Malls	FREMANTLE	6160
Perth (East, North & South Metro)	WA	Perth Carer Respite Centre - Stirling Office	164a Scarborough Beach Road	SCARBOROUGH	6019
Pilbara Region	WA	Pilbara Carer Respite Centre	Morgans Street	PORT HEDLAND	6721
South West Region	WA	South West Carer Respite Centre	Shop 5, 91 Victoria Street	BUNBURY	6230
South West Region	WA	South West Carer Respite Centre – Mandurah Office	Shop 18, The Plaza, Tuckey Street	MANDURAH	6210

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000080

Topic: HOME AND COMMUNITY CARE (HACC) PROGRAM – COLLECTION OF DATA

Written Question on Notice

Senator Evans asked:

(a) Did the collection of the HACC minimum data set begin as scheduled on January 1, 2001?

(b) If not, why not?

(c) When will we see the data reported?

Answer:

(a) Yes

(b) Not applicable.

(c) The Department will receive reports on the first quarterly collection in May 2001. However, the data in the first two collections is unlikely to be robust enough to merit publication. The first annual report of national HACC data will be for the year 2001-02 and will be available around October 2002. States will also receive data for their State at the same time as the Commonwealth receives national data.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000081

Topic: HOME AND COMMUNITY CARE PROGRAM (HACC) – TARGETING FRAMEWORK

Written Question on Notice

Senator Evans asked:

What progress has been made in developing a targeting framework for the HACC Program based on the 7 targeting strategies identified in Anna Howe's 1999 Report ? (the May 2000 meeting of HACC officials agreed to this).

Answer:

The *Targeting in the Home and Community Care* report produced by Anna Howe and Len Gray made a number of recommendations in relation to the Home and Community Care (HACC) Program.

In relation to the seven targeting strategies identified in the report, these are listed in the revised draft HACC National Program Guidelines, to guide service providers in allocating resources. The Guidelines emphasise that the targeting strategies are not prioritised and each strategy is of equal value and importance in meeting the needs of individuals and the Program as a whole.

In relation to the development of a targeting framework, a Targeting Working Group (TWG) has been established to consider the options and implications for implementing such a framework. The TWG is comprised of high level representatives from the Commonwealth and each State and Territory.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000082

Topic: HOME AND COMMUNITY CARE (HACC) PROGRAM – MEETING OF ADMINISTRATORS

Written Question on Notice

Senator Evans asked:

What was the outcome of the meeting of administrators of the HACC Program and CSDA Services (Scheduled for mid November, 2000) to address criticisms made in the Audit Office report on HACC (with respect to overlap and boundaries between services provided for younger people with disabilities under both programs?

Answer:

24 senior administrators of the HACC Program and Disability Programs from the Commonwealth and all States and Territories met in November 2000 to improve collaboration between the programs and address concerns regarding program overlaps and boundaries. The following outcomes were achieved.

- Areas of common interest were identified, including client assessment, continuity of care, program planning and data collection;
- It was agreed that examples of collaboration between programs, where service providers had devised local solutions to overcome demarcation issues, would be compiled. These examples of collaborative efforts will be shared with all jurisdictions at the next meeting, with a view to establishing joint 'shared solution' trials, initially for medium and high support need clients;
- Reciprocal membership on a number of working groups was agreed to, including inviting a representative of National Disability Administrators to join the HACC Assessment Working Group.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000083

Topic: HOME AND COMMUNITY CARE (HACC) PROGRAM - DVA

Written Question on Notice

Senator Evans asked:

(a) Are DVA now providing HACC services to Veterans in accordance with policy announced in the last Budget?

(b) What level of resources has this freed up under the HACC program?

Answer:

(a) DVA's Veterans' Home Care Program commenced operation in January 2001. Organisations have been contracted to provide assessment, co-ordination and home care services, and services have commenced in all States and Territories.

(b) Estimate at the time of the 2000-2001 Budget was that 20,000 places would be freed up for the general HACC Program.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000084

Topic: HOME AND COMMUNITY CARE (HACC) PROGRAM – STATE PLANS

Written Question on Notice

Senator Evans asked:

(a) Did the latest round of State plans specify HACC program outputs by region?

(b) Can you provide the average unit cost for each HACC service (eg nursing, personal care, home maintenance, meals etc) for each State?

Answer:

(a) Yes.

(b) No. State HACC Plans only specify planned expenditure. HACC Business Reports should contain actual expenditure and outputs achieved but the Department has not yet received a full set of Business Reports from the States.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000085

Topic: HOME AND COMMUNITY CARE (HACC) PROGRAM - COMPENSATION

Written Question on Notice

Senator Evans asked:

(a) In the allocation of HACC funds between and within states is there any compensation for differing levels of residential care?

(b) Do states which have a lower provision of residential care get additional resources to compensate for a higher HACC target population?

Answer:

(a) In regard to allocations between States, the answer is no. In regard to allocations within States, the planning process considers a wide range of indicators of need and this process varies from State to State. There is no direct connection between residential care provision and HACC allocations, but there may be an indirect relationship in that in some regions residential care provision may be considered to reduce the need for community care.

(b) The HACC program through its planning process takes into account supply side data from other program areas, such as Residential Care, Community Aged Care Packages and Respite for Carers.

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000024

Topic: WAITING TIMES

Written Question on Notice

Senator Evans asked:

Can the Department provide an update on the information provided in Q155 to a question asked on 1 June 1999, specifically can the Department provide the average waiting time in days for the States and regions specified in that question for the year 1999-2000.

Answer:

There is no national collection of waiting time data, although residential care homes may maintain their own waiting lists. For older people who do not require an immediate admission there are many reasons why the elapsed time is not a good measure of demand.

The elapsed time from ACAT approval to entry into an aged care home is not the same as waiting time. This is because older people and their families need time after the ACAT interview to decide whether to enter residential care, to visit a number of homes and to organise their affairs before moving. In many cases, older people have not yet made the decision to enter residential care at the time of their ACAT assessment. Some older people may obtain an ACAT assessment and then wait for a place in a particular aged care home that suits their needs, including their religious and other preferences.

Of course, urgent placements are sometimes required, and when this is the case, a place can generally be found very quickly. For example, around 15 per cent of high care residents enter within 2 days and 28 per cent within 7 days of ACAT approval.

Respite care has a significant and demonstrable effect in delaying entry into permanent care. Respite care allows older people to receive residential aged care for a short period of time. It assists them to remain in the community by giving them more intensive care and their carers a short break from caring. Some people who are approved for permanent care prefer to enter respite care while they put their affairs in order and find a service that suits their needs. During 1999-2000, only 20 per cent of high care residents who had previously used residential respite care entered residential care in less than 14 days of an ACAT assessment compared to 44 per cent of people who had not previously used residential respite care.

As part of the October 1997 Aged Care Reforms, an ACAT approval for high level care admission was made valid for one year (to bring it in line with the low level approval period) rather than the 90 days which applied previously. This has taken pressure off people entering high level care and given them more time to make decisions. The change in high level care ACAT approval to one year also has removed the incentive for ACATs to postpone an approval until they are sure the resident could find a place within 90 days, as was sometimes the case in the past. This has created a break in the data series from 1997-98 to 1998-99 in respect of high care. Therefore comparisons between 1997-98 and 1998-99 for high care are not valid.

Entry periods expressed as an average number of days (the format used to present the information in Q155 to a question asked on 1 June 1999) is not a valid presentation of the data. In statistical terms, the distribution of entry periods is extremely skewed. Averages are notoriously bad as measures of such distributions. For example, more than two thirds of all residents enter care in less than the average entry time. The Steering Committee for the Review of Commonwealth/State Service Provision has chosen not to express this indicator as an average number of days in its recent *Report on Government Services 2001*.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000025

Topic: WAITING TIMES

Written Question on Notice

Senator Evans asked:

Can the Department provide for each planning region the average waiting time in days for the years 1996-97, 1997-98, 1998-1999 and 1999-2000.

Answer:

Please see the answer provided for Question E01000024.

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000026

Topic: HOSPITAL LEAVE

Written Question on Notice

Senator Evans asked:

Can the Department provide an update on the information provided in Q171 to a question asked on 1 December 1999, specifically can the Department provide the number of hospital leave days and extended leave episodes by State for the year 1999-2000.

Answer:

State	Hospital leave days 1999-2000	Extended leave episodes of 30 days or more, 1999-2000
NSW	244,133	1,655
VIC	179,750	1,395
QLD	127,414	719
WA	82,871	586
SA	66,902	353
TAS	12,025	77
ACT	6,878	34
NT	1,642	7
AUSTRALIA	721,615	4,826

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000027

Topic: HOSPITAL LEAVE

Written Question on Notice

Senator Evans asked:

Can the Department provide the average number of hospital leave days per resident for each State in 1997-98, 1998-99 and 1999-2000.

Answer:

This table shows the average number of hospital leave days for residents since 1 October 1997. The figures for 1997/98 are for the part year since 1 October 1997, from the commencement of the *Aged Care Act 1997.*

State	1997-98	1998-99	1999-2000
NSW	4.3	4.7	5.1
VIC	4.7	5.3	5.4
QLD	5.0	5.2	5.2
WA	6.5	6.8	7.3
SA	5.3	5.2	5.0
TAS	3.1	3.0	3.2
ACT	5.1	4.5	4.9
NT	6.0	3.6	4.6
AUSTRALIA	4.8	5.1	5.3

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000028

Topic: REPORTS ON GOVERNMENT SERVICES – NURSING HOME PATIENTS

Written Question on Notice

Senator Evans asked:

In the 2000 Report on Government Services the Productivity Commission included information on nursing home type patients in each State (p. 944). Does the Department have more up to date information on the numbers of nursing home type patients in public hospitals? If so can the Department provide information in the same format as included in the Productivity Commission report for the years 1998-99 and 1999-2000.

Answer:

In preparing the Report on Government Services, the Steering Committee for the Review of Commonwealth/State Service Provision collects information on so-called nursing home type patients from the State and Territory Governments. The Department of Health and Aged Care is not involved in this collection process. I am advised that the Steering Committee decided, in preparing the 2001 Report on Government Services, that inconsistencies in definition and measurement over time and between States and Territories rendered the data not sufficiently valid to be reported.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000029

Topic: AGED CARE EXPENDITURE

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate how much was raised through the income tested fee in each of the years 1997-98, 1998-99 and 1999-2000?

(b) What are the Department's latest estimates for the amounts that will be raised in 2000-01, 2001-02, 2002-03?

(c) What is the Department's cost of administering the income tested fee?

(d) Can the Department confirm that those paying the income tested fee are potentially eligible for a tax rebate, for medical expenses, on the amount paid and that this rebate may result in 48.5% of the fee being returned?

Answer:

(a) The following amounts have been raised through the income tested fee;
- 1997-98 $0.567m;
- 1998-99 $15.381m;
- 1999-00 $37.468m.

(b) Its estimated that the following amounts will be raised through the income tested fee;
- 2000-01 $51.984m;
- 2001-02 $63.029m;
- 2002-03 $71.457m.

(c) The Department's estimates about $4.8m per annum.

(d) According to the Australian Taxation Office, income tested fees paid by residents whose care need classification is not the lowest (ie. not Resident Classification Scale category 8) qualify as medical expenses for the purpose of the medical expenses rebate. The available rebate is 20% of the net medical expenses above $1,250.

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000030

Topic: AGED CARE EXPENDITURE

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate the cost of the concessional resident supplement for each of the years 1997-98, 1998-99, 1999-2000?

(b) What are the Department's latest estimates for the cost of the supplement in 2000-01, 2001-02, 2002-03?

Answer:

(a) The expenditure on concessional resident supplement was;

- $15.7m in 1997-1998
- $72.8m in 1998-1999
- $124.1m in 1999-2000

(b) The Department's current estimates of concessional resident supplement in constant prices (ie excluding indexation) are:

- $178.0m in 2000-2001
- $210.3m in 2001-2002
- $236.3m in 2002-2003

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000031

Topic: AMOUNTS RAISED THROUGH CHARGES

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate the estimated amounts raised through the accommodation charge for each of the years 1997-98, 1998-99 and 1999-2000?

(b) What are the Department's latest estimates for the amounts that will be raised in 2000-01, 2001-02 and 2002-03?

Answer:

(a) The amount raised through accommodation charges is estimated to have been $31.2m in 1997-98, $59.8m in 1998-99 and $95.8m in 1999-2000.

(b) The Department estimates that accommodation charges will raise $123.1m in 2000-01, $147.8m in 2001-02 and $172.5m in 2002-03.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000032

Topic: AMOUNTS RAISED THROUGH BONDS

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate the estimated amounts raised through the accommodation bond for each of the years 1997-98, 1998-99 and 1999-2000?

(b) What are the Department's latest estimates for the amounts that will be raised in 2000-01, 2001-02 and 2002-03?

Answer:

(a) The amount raised through accommodation bonds is estimated to have been $61.0m in 1997-98, $117.0m in 1998-99 and $187.5m in 1999-2000.

(b) The Department estimates that accommodation bonds will raise $240.9m in 2000-01, $289.1m in 2001-02 and $337.5m in 2002-03.

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000033

Topic: NUMBER OF LARGE BONDS

Written Question on Notice

Senator Evans asked:

Given the requirement of providers to provide information on accommodation bonds, can the Department indicate by each State the number of people paying a large bond, i.e. how many people are paying a bond of $150,000-200,000, $200,001-$250,000 and $250,001+?

Answer:

The Department of Health and Aged Care does not collect such data on the bonds paid by individual residents.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000034

Topic: LARGEST BOND PAID

Written Question on Notice

Senator Evans asked:

What is the largest bond paid by a resident that the Department is aware of?

Answer:

See answer to question E01000033.

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000035

Topic: AGED CARE PLANNING

Written Question on Notice

Senator Evans asked:

(a) Can the department provide the membership of each Aged Care Planning Advisory Committee, indicating their membership of any relevant organisation.

(b) How are those members appointed?

(c) What is the length of their appointment?

Answer:

(a) Individuals are appointed to the Aged Care Planning Advisory Committees (ACPACs) for a set period. Previous appointments expired on 30 April 2000. The Department of Health and Aged Care is preparing to appoint new members to the ACPACs for the 2001 Aged Care Approvals Round.

(b) Under section 12-7 of the *Aged Care Act 1997*, ACPACs are established by the Secretary of the Department. ACPAC appointment details are set out in Part 4, Division 5 of the *Allocation Principles 1997* (the Principles).

Under paragraph 4.17 of the Principles, an ACPAC consists of a chairperson and at least seven and not more than ten other members. The chairperson must be an officer of the Department. At least one member of the ACPAC, other than the chairperson, must be a government officer who has experience in the administration or delivery of aged care services by the Commonwealth or a State/Territory. A local government representative will also be appointed.

When choosing a person for appointment as a member of an ACPAC, the Delegate of the Secretary must consider the person's:

- personal knowledge of, and experience in, the delivery of aged care; and
- ability to contribute to the planning of aged care and give effective advice to the Secretary.

Paragraph 4.18(2) of the Principles requires that "a person must not be chosen for appointment as a member of a committee solely on the basis of the person's capacity to represent a particular body or group."

In addition, the Principles require that non-government members of a committee, between them, have knowledge of, or experience in, each of the following:

- The operations of aged care providers;
- Aged care services from the perspective of consumers of the service;
- The delivery of aged care to people from culturally or linguistically diverse backgrounds;
- The delivery of aged care services to people from Aboriginal and Torres Strait Islander communities;
- The delivery of aged care services to people living in rural and remote areas; and
- The delivery of aged care services to ex-servicemen or ex-servicewoman.

(c) Under section 4.19 of the Principles, the Secretary must not appoint a person as a member of an ACPAC for a term of more than two years. However, a member is eligible for reappointment.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000036

Topic: AGED CARE PLANNING

Written Question on Notice

Senator Evans asked:

Can the Department provide the projected populations of those aged 70 and over in each planning region for the years 2001 and 2002.

Answer:

This information is publicly available through the ABS.

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000037

Topic: REPORT ON THE OPERATION OF THE AGED CARE ACT

Written Question on Notice

Senator Evans asked:

In the most recent Report on the Operation of the Aged Care Act (pp. 26-27) the Department included projections on the amounts to be raised through bonds and charges.

(a) Can the Department provide the methodology for those projections?

(b) Why is there significant growth in both to the year 2004-05 and then a slowing of that growth?

(c) The graph appears to indicate that $60 million was raised by the accommodation charge in 1998-99, yet in response to a question on notice in the Senate the Department has indicated that $84 million was raised, can the Department explain this discrepancy?

(d) Can the Department provide a version of the graph included in the Report on the Operation of the Act (p. 20) that only includes operational places to the year 2000.

(e) Can the Department account for the extended delay in the tabling of the Report, which was due on 30 September 2000. In particular when was the report provided to the Minister, when was the report approved by the Minister, when was it sent to the printers and when were copies available for circulation?

Answer:

(a) Residential aged care providers were surveyed about building activity being undertaken by providers and the level of income derived by providers from accommodation bonds and charges. The projections of future income that providers will receive from bonds and charges are derived from this survey data. They are adjusted for the effects of CPI, the increase in the number of operational places and the replacement of pre-1 October 1997 residents by post-1 October 1997 residents. (Only residents entering after that date may be charged an accommodation charge).

(b) Of the growth factors mentioned in (a) the replacement of pre-1 October 1997 residents by post-1 October 1997 residents will cease to have a significant effect after 2004-05 as almost all of the pre-1 October 1997 residents will have left services.

(c) The Department is not a direct party to the agreement between providers and residents relating to the level of accommodation charges. The response of $84 million that was provided in 1999 was an estimate based on the data available to the Department at the time. The figure of $59.8 million in the Report on the Operation of the Aged Care Act is based on actual survey data of aged care providers.

(d) See Report for all relevant data.

(e) The year, which is the subject of the current report, concluded on 30 June 2000. In order to meet the legislative reporting requirements it is necessary to survey aged care providers. The time available between 30 June and 30 September is a very short period in which to conduct a national survey, follow-up responses from providers, collate and analyse those responses and draft a report. In relation to the timetable please see the attached letter (Attachment A). It was available for circulation when accepted by the President of the Senate.

29 January 2000

Tabling Officer
Prime Minister & Cabinet
Suite RG98
Parliament House
CANBERRA ACT 2600

Report on the Operation of the *Aged Care Act 1997*: 1 July 1999 to 30 June 2000.

Enclosed are five copies of the above report, which was submitted to the Minister for Aged Care on 19 January 2001 and received by the Minister on 19 January 2001. The Minister approved the tabling of the document on 29 January 2001.

Attached is a copy of the letter from the Minister for Aged Care to the President of the Senate, relating to the presentation of documents when the Senate is not sitting.

The requirements for tabling are set out under Section 63.2 of the *Aged Care Act 1997*.

The required number of copies of the report has been delivered to the Parliament House.

It would be appreciated if you could make arrangements to have the report tabled in the House of Representatives as soon as possible.

If you have any queries please contact Jane Hanson on 6289 5496.

Yours sincerely

Andrew Stuart
Assistant Secretary
Policy and Evaluation Branch
Aged and Community Care Division

Telephone: 6289 5475
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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000038

Topic: RCS REVIEWS

Written Question on Notice

Senator Evans asked:

Can the Department provide, by State, the number of validation reviews of care records and the outcome of those reviews, ie number of upgrades and downgrades for the years 1997-98, 1998-99 and 1999-2000.

Answer:

This information is provided publicly through the quarterly RCS Statistic publication.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTALIANS **Question: E01000039**

Topic: ACT AND PRINCIPLES

Hansard Page: CA 3

Senator Evans asked:

Can the Department provide a copy of the most recent print of the Aged Care Act and Principles?

Answer:

Yes.

An electronic copy can also be found at
http://www.health.gov.au/hfs/acc/legislat/aca1997/acaindex.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question:E01000040

Topic: PLACES TARGETED AT PEOPLE WITH "SPECIAL NEEDS"

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate the number of operational places in each planning region targeted at both people from a non-English speaking background (separately specifying each cultural group, eg Chinese, Dutch) and Indigenous Australians. Separately identify for each group the number of high and low residential and community care places available.

(b) Can the Department provide a similar break down for the recent allocation round.

Answer:

(a) No.

(b) Please see attached Tables 1 and 2.

Attachment A

Table 1

2000 Aged Care Approvals Round - Approvals for Indigenous Places by Aged Care Planning Regions

Planning Region	**ATSI Places**	**Care Type**
ACT/Southern Highlands	20	Community Aged Care Packages
Alice Springs	45	Community Aged Care Packages
All Metro - Vic	14	Community Aged Care Packages
Barkly	8	Community Aged Care Packages
Barwon-Southwestern	6	Community Aged Care Packages
Brisbane South	2	Residential Care Places - High
Brisbane South	8	Residential Care Places - Low
Central Coast	11	Community Aged Care Packages
Central West	7	Community Aged Care Packages
Darling Downs	4	Community Aged Care Packages
Darwin	16	Residential Care Places - High
Darwin	6	Community Aged Care Packages
East Arnhem	16	Community Aged Care Packages
Far North	26	Community Aged Care Packages
Far North Coast	6	Community Aged Care Packages
Fitzroy	11	Community Aged Care Packages
Goldfields	23	Community Aged Care Packages
Hume	20	Community Aged Care Packages
Hunter	10	Community Aged Care Packages
Illawarra	14	Community Aged Care Packages
Kimberley	2	Community Aged Care Packages
Logan River Valley	10	Community Aged Care Packages
Metropolitan East - WA	2	Community Aged Care Packages
Metropolitan South - WA	5	Community Aged Care Packages
Metropolitan West - SA	15	Community Aged Care Packages
Mid North Coast	44	Community Aged Care Packages
Mid West	8	Community Aged Care Packages
Midlands	5	Community Aged Care Packages
New England	24	Community Aged Care Packages
North West	4	Community Aged Care Packages
North Western	8	Community Aged Care Packages
Northern	10	Community Aged Care Packages
Orana Far West	28	Community Aged Care Packages
Pilbara	20	Residential Care Places - Low
Riverina/Murray - NSW	30	Community Aged Care Packages
Riverina/Murray - VIC	7	Community Aged Care Packages
South East	7	Community Aged Care Packages
South East Sydney	10	Community Aged Care Packages
South West - QLD	13	Community Aged Care Packages
South West - WA	15	Community Aged Care Packages
Southern Highlands		Residential Care Places - High
Sunshine Coast	15	Community Aged Care Packages
Whyalla, Flinders & Far North	21	Community Aged Care Packages
	576	

Attachment A
Table 2

2000 Aged Care Approvals Round - Approvals of Places Targeted for People from Non-English Backgrounds

Region	Places	Care Type
ACT	8	Community Care Packages
Barwon-Southwestern	8	Community Care Packages
Brisbane North	55	Community Care Packages
Brisbane South	50	Community Care Packages
Central Coast	10	Community Care Packages
Eastern Metro	60	Residential Care Places - Low
Eastern Metro	30	Community Care Packages
Eastern Metro VIC	10	Community Care Packages
Far North Coast NSW	50	Residential Care Places - Low
Hume	14	Community Care Packages
Hunter	12	Community Care Packages
Illawarra	15	Community Care Packages
Inner West	58	Community Care Packages
Inner West	19	Residential Care Places - Low
Logan River Valley	10	Community Care Packages
Mackay	15	Community Care Packages
Metropolitan East - WA	7	Community Care Packages
Metropolitan North - SA	38	Residential Care Places - Low
Metropolitan North - WA	15	Community Care Packages
Metropolitan South - WA	29	Community Care Packages
Metropolitan West - SA	20	Residential Care Places - Low
Multiple Metro - SA	25	Community Care Packages
Multiple Metro - Vic	30	Community Care Packages
Nepean	8	Community Care Packages
Northern	10	Community Care Packages
Northern Metro	10	Community Care Packages
Northern Metro	60	Residential Care Places - Low
Northern Sydney	15	Community Care Packages
Riverina/Murray	15	Residential Care Places - Low
South Coast	15	Community Care Packages
South East Sydney	45	Community Care Packages
South West Sydney	51	Community Care Packages
South West Sydney	32	Residential Care Places - Low
Southern	18	Residential Care Grant
Southern Metro	60	Residential Care Places - Low
Southern Metro VIC	20	Community Care Packages
Western Metro	60	Residential Care Places - Low
Western Metro	28	Community Care Packages
Western Sydney	21	Community Care Packages
Western Sydney	49	Residential Care Places - Low
	1105	

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000041

Topic: SURPRISE INSPECTIONS

Written Question on Notice

Senator Evans asked:

(a) Can the Department and Agency confirm how many surprise inspections were conducted in 2000 and how many have been carried out to date in 2001 in each State.

(b) Can the Department and Agency indicate how many separate facilities have been the subject of a surprise inspection in 2000 and in 2001 in each State. If facilities have been the subject of more than one surprise inspection these figures will be less than the totals in the previous question.

Answer:

(a) Number of surprise inspections conducted in 2000

SA	133
NT	6
NSW	128
ACT	6
WA	37
VIC	304
TAS	6
QLD	57
TOTAL	**677**

Number of surprise inspections conducted in 2001 (cob19 February 2001) in each State

SA	20
NT	1
NSW	21
ACT	1
WA	3
VIC	118
TAS	2
QLD	21
TOTAL	**187**

(b) Number of separate facilities which have been the subject of a surprise inspection in 2000 in each State

SA	27
NT	6
NSW	105
ACT	5
WA	31
VIC	144
TAS	6
QLD	53
TOTAL	**377**

Number of separate facilities which have been the subject of a surprise inspection in 2001 (cob19 February 2001) in each State

SA	18
NT	1
NSW	21
ACT	1
WA	3
VIC	81
TAS	2
QLD	22
TOTAL	**149**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000042

Topic: SURPRISE INSPECTIONS

Written Question on Notice

Senator Evans asked:

Separately indicate the number of review audits that were conducted in 1999 and in 2000.

Answer:

In 1999 the Agency conducted 175 review audits (including assessments under the former Principles) and in 2000, the Agency conducted 146 review audits.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000043

Topic: COST OF CONSTRUCTING A RESIDENTIAL PLACE

Written Question on Notice

Senator Evans asked:

(a) Can the Department provide its best estimate of constructing a residential place as at 2001.

(b) What is the basis for this estimate?

(c) Does this figure cover the entire cost of establishing the bed ready for use, i.e. land costs, design and approval, construction, furnishing and equipping?

(d) Can the Department provide a breakdown of the figure into these components?

(e) Does the Department's estimate of the cost of establishing a bed take into account the cost of a design required to meet the certification standards of 2008?

(f) Does the Department take into account differences across States and regions?

(g) Does the Department have any estimates on the different costs across States and regions?

Answer:

(f) The Department of Health and Aged Care estimates that the income stream provided by accommodation bonds and charges, together with the capital component of Commonwealth recurrent funding and the Commonwealth's targeted capital assistance grants, is sufficient to provide for the industry's capital needs.

(g) See above.

(h) See above.

(i) See above.

(j) See above.

(k) See above.

(l) See above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000044

Topic: RECOVERY OF GRANT

Written Question on Notice

Senator Evans asked:

(a) Can the Department confirm that the Manellae Lodge in Manilla NSW was the recipient of a grant to establish that facility?

(b) What was the value of that grant?

(c) Can the Department confirm that in cases where such a facility is sold the provider is required to return a proportion of that grant?

(d) What is the methodology used in calculating the amount to be returned in such cases?

(e) What amount will be required to be returned by the provider of the Manellae Lodge on the sale of that facility?

(f) Is there any flexibility or discretion on the part of the Department in determining both the size and timing of this refund of grant monies?

Answer:

(a) Yes.

(b) The grant amount was $627,295.

(c) Whether or not the provider is required to return any portion of the grant if the home is sold depends on the circumstances of the case.

(d) Each case is considered on its merits, having regard to the specific circumstances of the sale, including matters such as: the period since the grant was provided; whether home is being sold in the commercial market and whether the sale of the home would result in significant financial gain to the provider; and whether to seek recovery of the grant would impede the achievement of broader Commonwealth aged care policy objectives.

(e) See (d).

(f) Yes. The Secretary has discretion to determine the amount of grant, if any, to be refunded and to determine other conditions such as the timing of any refund, as part of the conditions of approval of disposal of the home.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000269

Topic: ACCREDITATION

Hansard Page: CA 144/145

Senator Evans asked:

(a) Provide a breakdown by state of the numbers of providers who received three-year accreditation, one-year accreditation, and so on?

(b) Have any services had their accreditation revoked since 1 January? Have any had the period of accreditation reduced, if so, how many?

Answer:

(a) Refer to Question E01000045.

(b) Between 1 January 2001 and 30 April 2001, 33 review audits of accredited services were conducted. Decisions on 26 of these had been made in that period. Of those 26 decisions, nine were to reduce the period of accreditation; none was to revoke accreditation; 17 were not to vary the period of accreditation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E1000045**

Topic: ACCREDITATION

Written Question on Notice

Senator Evans asked:

Can the Agency provide a summary of the outcome of accreditation, indicating by State the number of facilities that gained 3-year, 1-year accreditation and those that failed accreditation.

Answer:

The accreditation status of aged care services as at 30 April 2001 was as follows:

Accreditation Status	NSW/ ACT	VIC	QLD	SA/ NT	WA	TAS	TOTAL
Services accredited for one-year	29	71	44	11	22	1	**178**
Services accredited for three years	921	731	448	297	240	95	**2732**
Services accredited for other periods	1	10	3	9	5	1	**29**
Services not accredited and not obtaining exceptional circumstances		1					**1**
Services having exceptional circumstances granted	2	15	0	0	1	1	**19**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000046

Topic: IMPLICATIONS OF FAILED ACCREDITATION

Written Question on Notice

Senator Evans asked:

(a) What are the implications of a facility failing accreditation or having accreditation revoked after 1 January 2001?

(b) What would be the process of stopping the funding of such a facility?

Answer:

(a) The relevant approved provider is not eligible to receive residential care subsidy unless the Secretary determines, or has determined, that the home is taken to meet its accreditation requirement.

(b) Approved providers are paid subsidy in advance based on estimates, taking into account matters such as the number of allocated places and the category of the residents. The approved provider later submits a claim based on actual figures and an appropriate adjustment is made.

The Aged Care Standards and Accreditation Agency (the Agency) has the power not to accredit or revoke or vary a home's accreditation. If a home's accreditation is revoked the Agency is obliged to tell the Secretary of the Department as well as the relevant approved provider.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000047

Topic: CONTINGENCY PLANS

Written Question on Notice

Senator Evans asked:

(a) Can the Department outline the contingency plans it had in place for possible closures on 1 January, specifically how many places were potentially available to accommodate residents that might have been evacuated?

(b) Can the Department confirm that discussions had been held with hotels/motels and hospitals as possible sites to accommodate residents?

Answer:

(a) The Department undertook a process to identify suitable premises in each State and Territory to which residents could be relocated if the need arose. Nationally, in excess of 100 premises were identified as possible temporary/emergency accommodation options.

(b) In the process of identifying suitable premises the Department held discussions with a wide range of possible providers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000048

Topic: MONTHLY BREAKDOWN BY STATE (2000)

Written Question on Notice

Senator Evans asked:

Can the Department provide a monthly breakdown of the complaints received in 2000 by State.

Answer:

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
NSW	28	36	87	43	55	44	53	88	59	37	49	41
VIC	28	37	85	45	48	23	29	39	33	38	38	23
QLD	32	41	57	33	45	24	33	28	35	26	19	18
SA	7	10	29	22	18	11	17	7	14	15	14	9
WA	5	26	26	16	19	7	11	18	12	13	11	12
NT	0	1	0	1	3	1	1	0	0	0	0	0
ACT	2	3	7	2	5	3	1	3	1	3	3	2

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000049

Topic: RECOMMENDATION SEVEN OF THE OMBUDSMAN'S INQUIRY

Written Question on Notice

Senator Evans asked:

Can the Department confirm that recommendation seven of the Ombudsman's inquiry into the Complaints Scheme has been implemented? It appears that the necessary change to the Principles have not been introduced.

Answer:

No changes to the *Committee Principles 1997* are required. The requirement that all aged care homes have a complaints handling system is legislated in the Accreditation Standards, *Quality of Care Principles 1997*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E0100050**

Topic: SANCTIONS

Written Question on Notice

Senator Evans asked:

Can the Department provide, by State, the number of sanctions imposed on facilities in each of the months in 1998,1999 and 2000.

Answer:

Year	State	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
1998	VIC			1			1						1
1999	VIC		1	1									
2000	VIC		2	2		3		3	2	3	4	1	
	WA									1			
	SA							2	2	2	2		
	NSW						4	1	1				
	QLD											2	

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000051

Topic: NATIONAL STRATEGY FOR AN AGEING AUSTRALIA –EMPLOYERS GROUP

Written Question on Notice

Senator Evans asked:

(a) Can the Department provide details on the members of the employers group convened by the Minister, including who was invited, who has attended and what is the objective of the group.

(b) How many times has it met?

Answer:

(a) The following people were invited to join, and are members of, the Business Mature Age Workforce Advisory Group chaired by the Hon Bronwyn Bishop MP, Minister for Aged Care:

Mr Roger Corbett, Chief Executive, Woolworths Ltd
Mr Graeme John, Managing Director, Australia Post
Mr Jean-Georges Malcor, Managing Director, ADI Ltd
Dr Ken Moss, Chairman, Boral Ltd
Mr Maurice Newman, Chairman, Australian Stock Exchange
Mr John Pascoe, Managing Director – Insurance and Financial Services, Phillips Fox Lawyers; Chairman, Centrelink
Mr John Studdy, Chairman, Network Ten

Most meetings have had not less than 70 per cent attendance.

The Business Mature Age Workforce Advisory Group was convened to focus on the issue of mature age employment with a view to bringing about a change of culture so that the skills and the experience of mature age workers are valued by employers.

(b) The Business Mature Age Workforce Advisory Group has met four times.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000052

Topic: NATIONAL STRATEGY FOR AN AGEING AUSTRALIA - MINISTERIAL REFERENCE GROUP

Written Question on Notice

Senator Evans asked:

Can the Department indicate when the Ministerial reference Group for the Strategy has met and who attended.

Answer:

The Ministerial Reference Group for the National Strategy for an Ageing Australia has met on six occasions.

The meetings have been attended by a combination of Ministers and/or their senior advisers and Departmental staff.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000053

Topic: RESIDENTIAL AGED CARE FUNDING

Written Question on Notice

Senator Evans asked:

Can the Department provide a breakdown of the increase in residential aged care funding between 1995-96 and 2001-02. In particular can the Department indicate what proportion of the increase in funding was due to an increase in residents numbers, what proportion was due to the indexation of subsidies, what proportion was due to an increase in the dependency of residents and other reasons (eg the transfer of rent allowance from FACS).

Answer:

53% of growth is due to new places and indexation. 47% is due to policies for better care including increases in resident dependency, including ageing in place.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000062

Topic: AIR CONDITIONING

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate whether air conditioning is a requirement for certification?

(b) Is it the case in all areas, if not then where is air conditioning required?

Answer:

(a) Air conditioning is not required under certification.

(b) The July 1999 instrument scores a service's provision of cooling and heating in terms of the requirements of the climatic zone in which the service is located. A service will score well if it provides a high standard of cooling and heating that is appropriate to its climate.

In addition, Accreditation Outcome 4.4 (Living Environment) requires the Aged Care Standards and Accreditation Agency to take into account the extent to which a service identifies and responds to residents' needs and preferences for a safe and comfortable environment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000063

Topic: CONSULTATION ON NEW PRINCIPLES

Written Question on Notice

Senator Evans asked:

(a) Can the Department outline its consultation process in developing the Principles required for the implementation of the provisions related to the disqualification of key personnel?

(b) Who was consulted and what was the timing of the consultation?

Answer:

(a) Yes, see (b) below.

(b) There was a full range of consultations with stakeholders following the enactment of the legislation in December 2000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E0100064**

Topic: DISQUALIFICATION OF KEY PERSONNEL – MR MENERE

Written Question on Notice

Senator Evans asked:

(a) When exactly did the Department confirm that Mr Graeme Menere had a conviction for an indictable offence?

(b) In the May 2000 hearing of estimates the Department indicated that they were investigating this matter, can the Department account for the delay in finally confirming this conviction?

Answer:

(a) On 4 January 2001 the Department received confirmation from its solicitors that Mr Graeme Menere did have a conviction for an indictable offence and would therefore be a "disqualified individual" under amendments to the *Aged Care Act 1997*.

(b) It was necessary to consider more than just whether Mr Menere was convicted of an indictable offence. The detail of the offence and its implications for the approved provider's suitability needed to be established before any further action could be contemplated. In the meantime amendments to the *Aged Care Act 1997* meant that a key personnel convicted of an indictable offence was automatically a disqualified individual. Therefore, there was no need to consider the full detail of the offence.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question:E01000065

Topic: DISQUALIFICATION OF KEY PERSONNEL

Written Question on Notice

Senator Evans asked:

(a) Has the Department received allegations about criminal convictions against any other providers?

(b) If so, how many?

(c) Without revealing the identity of the provider can the Department indicate when the allegation was first received in each case?

(d) Separately indicate the outcome of the investigation into each allegation, i.e. has the allegation been confirmed, proved untrue or still to be determined?

Answer:

(a) Yes.

(b) Since the passage of the amendments giving power to the Department to deal with key personnel convicted of indictable offences, there has been one allegation of a criminal conviction about one key personnel of one provider.

(c) February 2001.

(d) The allegation is still to be determined.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000258

Topic: CONVICTIONS AGAINST MR MENERE

Hansard Page: CA 149

Senator Evans asked:

When was this conviction recorded against Mr Menere?

Answer:

See answer to question E01000064.

Senate Community Affairs Legislation Committee

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HEALTH AND AGED CARE PORTFOLIO

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OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000259

Topic: MR MENERE'S SHAREHOLDINGS

Hansard Page: CA 151

Senator Evans asked:

Do you know what his shareholding is?

Answer:

ASIC records show he holds half the Saitta P/L shares and a 2/3 interest in Neviskia P/L.

Mr Menere ceased to be a director of both companies on 17 February 2001.

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000066

Topic: DISQUALIFICATION OF KEY PERSONNEL – CHRONOLOGY OF EVENTS

Written Question on Notice

Senator Evans asked:

(a) Has the Department investigated the criminal conviction of the provider noted in the Ombudsman's report on the Complaints Scheme?

(b) When was the Department first made aware of that conviction?

(c) Can the Department provide a chronology of the investigation into that conviction, i.e. indicate the month and year in which actions occurred.

Answer:

(a) The Department has investigated the criminal conviction referred to in the Ombudsman's report. Officers attended court proceedings and also sought information from the Transport Accident Commission. The Department ascertained that while a key personnel of an approved provider was convicted of an offence, following an appeal against the severity of the sentence, the conviction was sustained but reduced to "no conviction recorded".

(b) The Department first became aware of the conviction in September 1998, following an anonymous complaint.

(c) Chronology
September 1998 - The Department received an anonymous complaint concerning charges against key personnel (Director) of an approved provider
September 1998 - Departmental officers attended proceedings in the Melbourne Magistrates Court where charges were heard and a conviction recorded

December 1998 - The Department ascertained that subsequent to an appeal against the severity of the sentence, the conviction was sustained but reduced to "no conviction recorded".
December 1998 - The Department reviewed the status of the Approved Provider on the basis of the court proceedings and concluded that no action could be taken as the key personnel had not committed an indictable offence and no conviction was recorded.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000067

Topic: DISQUALIFICATION OF KEY PERSONNEL

Written Question on Notice

Senator Evans asked:

Will the Department continue to investigate allegations about criminal convictions against a provider, given the new provisions of the Act?

Answer:

Yes

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000086

Topic: AGED CARE PLACES – COMPARISON STATISTICS

Written Question on Notice

Senator Tchen asked:

Can you provide the committee comparison statistics of the number of places in the aged care system (operational and allocated) now and in 1996?

Answer:

Total Allocated Places

June 1996	144, 695
March 2001	182,214

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000087

Topic: AGED CARE PLACES – ANAO REPORT

Written Question on Notice

Senator Tchen asked:

What did the report of the Australian National Audit Office (ANAO) show with respect to the number of aged care places?

Answer:

The ANAO Audit Report No.19 (198-99) found that:

"Following the selection of care providers, the new places must be installed. Provision can require construction or addition of places in a residential facility, or growth in the capacity of a community care provider. On average, this phase takes two to three years for residential facilities, and about three months for community care packages. To provide enough time for industry providers to construct or to establish new capacity, DHAC approves or allocates these places 'in principle'. This is sufficient for the provider to install the service with the government guarantee of funding once the service becomes operational. In total, this means that the provision of new places to the aged occurs from one to three years or more after the particular point in time to which the estimate of need for the places refers.

From the client's perspective, however, AIPs are undertakings not yet available. The situation was that the number of operational aged care places in 1997 was approximately 6.5 per cent below the official target (or estimate of need), at 93.5 places for every 1000 persons. This shortfall is not temporary. Rather, it is inherent in the system since fulfilment of the provision of one year's AIPs will simply be replaced by the next year's unfulfilled AIP undertakings. To meet the target planning ratio immediately, an addition of nearly 10 100 places would be needed." (Audit Report No.19 (1998-99), p42)

In the last three Aged Care Approvals Rounds, 30,936 new places have been released.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000088

Topic: STAYING AT HOME INITIATIVE

Written Question on Notice

Senator Tchen asked:

How has the Government's Staying at Home Initiative impacted on the number of community aged care packages?

Answer:

The Staying at Home Initiative provided for the expansion of the Community Aged Care Package Program by 500 places in 1998-99 and 3,408 places over the period 1999-2000 to 2002-03, at an estimated cost of $95.5 million. This commitment has now been fully met, with the final 1,136 Packages due for release in the 2001 Aged Care Approvals Round.

Staying at Home has contributed to the unprecedented growth in the number of Community Aged Care Packages made available since 1996. With the release of 6,532 Packages in the 2000 Aged Care Approvals Round, national growth has exceeded 450%. In 1996 there were 4,431 Packages nationally. The new release will result in a total of 24,530 Packages operational by 30 June 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000089

Topic: CONTINENCE MANAGEMENT STRATEGY

Written Question on Notice

Senator Tchen asked:

(a) When was the Continence Management Strategy introduced?

(b) What is it doing to assist older Australians?

Answer:

(a) In the April 1998 *Staying At Home - Care and Support for Older Australians* package, the Prime Minister announced funding of $280m for initiatives to help older Australians living in the community to maintain their quality of life. The funding included $15m over four years to address the needs for improved continence management in aged care.

(b) The National Continence Management Strategy has two aims:

To reduce admission to residential aged care homes by improving the treatment and management of incontinence in older Australians, and

To address the early onset of continence problems, and thus improve quality of life in later years, through preventative strategies and community education.

A number of projects which will provide information for future policy and planning have commenced. These cover three main areas, and include:

1. Support for people with incontinence and their carers:
   - The National Continence Helpline – a freecall 1800 phone service, staffed by trained continence nurse advisors who offer information and support to callers.
   - Public Toilet Mapping – a national map of all public toilets in Australian towns and cities and along major travel routes.
   - Service Directory – a consumer directory of continence services nationally.
   - A Guide to Continence Products.
   - Continence Website.
   - Carer Education – a package is being developed to assist carers to maintain people with incontinence at home.
   - Public Awareness and information, including targeted Aboriginal and Torres Strait
   - Islander and Ethnic resources.

2. Research:
    - Aged Care Assessment Team (ACAT) and Resident Classification Scale (RCS) Data Analysis, which examines continence as a factor in admission to residential care.
    - Literature Review and Research Mapping – investigation into the prevalence and severity of incontinence.
    - Under-reporting – reasons for non-reporting of continence.
    - Outcome Measures – development of a suite of evaluation tools to support continence research.

3. Service Quality and Support for Health Professionals:
    - Continence Care and Resource Models – three community-based demonstration projects involving GP's, Pharmacies, and Community Nurses working together, trialing approaches to coordinated primary care.
    - Education of Health Professionals.

At the conclusion of the Strategy, a national framework for policy and planning will be developed to coordinate services and programs, address gaps, and recommend consistent approaches to continence management across Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000090

Topic: REFURBISHING AND UPGRADING IN AGED CARE HOMES

Written Question on Notice

Senator Tchen asked:

Can you inform the Committee of the extent of the refurbishing and upgrading work that has occurred in aged care homes?

Answer:

The Department of Health and Aged Care estimates that:

- Around a quarter of the building stock of the industry has been refurbished each year, during the years 1999 and 2000.
- The industry committed $1.4 billion on capital building works over the last two years (at 30 June 2000).
- 12 percent of services have been either newly built or completely rebuilt in the same period.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000091

Topic: AGED CARE EXPENDITURE

Written Question on Notice

Senator Tchen asked:

(a) What was the actual aged care expenditure in 1995/6?

(b) What is it this (2000/1) financial year?

Answer:

(a) Total Commonwealth expenditure on aged and community care in 1995/96 was $3.1 billion, including expenditure by the Department of Veterans' Affairs.

(b) Total Commonwealth expenditure on aged and community care in 2000/01, is forecast to be about $5.0 billion, including expenditure by the Department of Veterans' Affairs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000092

Topic: RURAL & REGIONAL AGED CARE PLACES

Written Question on Notice

Senator Tchen asked:

(a) What proportion of places went to rural and regional Australia in the recently announced aged care places round?

(b) What about capital expenditure?

Answer:

(a) 44% of the aged care places allocated in the 2000 Aged Care Approvals Round went to rural and regional locations.

(b) 74% of the capital grants allocated in the 2000 Aged Care Approvals Round went to services in rural and regional areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000093

Topic: COMPLAINANT'S RIGHTS

Written Question on Notice

Senator Tchen asked:

What is being done to protect the rights of residents and their families to complain about aged care homes?

Answer:

All aged care homes are required to have a complaints handling system. In addition, all homes have been asked to display brochures promoting the Complaints Resolution Scheme.

The Complaints Resolution Scheme was established in 1997 under the Aged Care Act and Principles. It provides a free and accessible complaints resolution scheme which aims by the use of negotiation and mediation to resolve complaints to the satisfaction of the complainant. Anyone can make a complaint to the Scheme about anything that affects a person who is, or was, receiving or eligible to receive Commonwealth-funded aged care services. These can be lodged either verbally or in writing and may be made as anonymous, confidential or open complaints.

Any person who needs help or support lodging a complaint may contact an advocacy service. Advocacy services play a unique role in consumer protection by promoting awareness of the rights of consumers of residential aged care services. They do this through the provision of information, advice, referral and support to clients in exercising their rights, through representation of consumers or their representatives, through education strategies to promote awareness of rights and through input to policy development.

The Commonwealth allocated $1,904,209 to advocacy services during the 2000/2001 financial year. This is an increase compared with the 1999/2000 financial year allocation of $1,751,026.

In August 2000, a new position of Commissioner for Complaints was also established. This position provides a vehicle for the oversight and scrutiny of the operations of the Scheme and provides it with a public voice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000094

Topic: AGED CARE SECTOR CODE OF CONDUCT AND ETHICAL PRACTICE

Written Question on Notice

Senator Tchen asked:

Has there been general community support for the Code of Ethical Practice and Conduct?

Answer:

As of 20 February 2001 over 130 responses had been received on the draft *Aged Care Sector Code of Conduct and Ethical Practice (*the *Code).* Generally there was support of the concept of the *Code*. Comments and suggestions that have been made in relation to the draft *Code* are currently been considered by the Code of Conduct and Ethical Practice Working Group in preparation of a revised *Code* for release at a later date.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000095

Topic: GOVERNMENT'S ACCREDITATION POLICIES

Written Question on Notice

Senator Tchen asked:

Can you inform the Committee how well has the industry accepted the Government's accreditation policies?

Answer:

A feedback questionnaire was given to all services at the conclusion of their site audit. The Agency received over 2000 responses. More than 90 per cent of respondents agreed or strongly agreed with the statement: "Overall, the site audit was a satisfying and useful experience".

The Agency's experience with the industry in respect of accreditation has been constructive and overwhelmingly positive, with the vast majority of services actively pursuing continuous quality improvement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000096

Topic: ACCREDITATION PROCESS

Written Question on Notice

Senator Tchen asked:

How many visits have there been as part of the accreditation process?

Answer:

To 31 December 2000, there were 2936 site audits for accreditation. It should be noted that commencing services do not undergo a site audit as a part of their accreditation application, and the above figure does not include additional site audits undertaken for the process of reconsideration, nor does it include support contacts or review audits.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3:ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question**: **E01000097**

Topic: COST OF INTERNATIONAL TRAVEL

Written Question on Notice

Senator Evans, Christopher asked:

(a) Can the Department provide separately the total cost of the Minister's two international trips as the Minister for Aged Care in 1999 and 2000?

(b) Can the Department provide an itinerary for each of the trips?

Answer:

(a) We have been advised by the Department of Finance and Administration that the total costs incurred by the Hon Bronwyn Bishop, Minister for Aged Care, in relation to her 25 July to 4 August 1999 visit to Hong Kong and Japan were $37,396.70. The information was tabled in the Parliament by the Special Minister of State on 8 June 2000 and 7 December 2000 as part of the regular six monthly tabling of travel and travel related expenses of Parliamentarians paid by the Department of Finance and Administration. Details of Parliamentarians' travel, including Mrs Bishop's 11-19 November 2000 visit to Singapore and Malaysia, are being compiled by the Department of Finance and Administration. They are expected to be tabled by 30 June 2001.

(b) Attachment A refers.

Question: E01000097

Attachment A

ITINERARY FOR MINISTER BISHOP'S TRADE MISSION TO HONG KONG AND JAPAN, 25 JULY – 4 AUGUST 1999

Sunday 25 July
- Depart Sydney for Hong Kong

Monday 26 July
- Meeting with Mr Tam Yiu-Chung, Commissioner for the Elderly
- Meeting with Mr Gregory Leung, Acting Secretary for Health and Welfare
- Meeting with Dr E K Yeoh, Chief Executive, Hong Kong Hospital Authority
- Visit Hong Kong Society for the Aged (SAGE) and the SAGE Chai Wan Multi-Service Centre for the Elderly
- Visit Haven of Hope Christian Centre

Tuesday 27 July
- Visit Quality Health Care, Fuk Kwan Elderly Care Home
- Visit Chi Lin Centre
- Host the Australian Aged Care Seminar in Hong Kong

Wednesday 28 July
- Depart Hong Kong for Osaka

Thursday 29 July
- Visit WHO Centre for Health Development, Kobe, Japan
- Meeting with Mr Kazutoshi Sasayama, Mayor of Kobe
- Host Australian Aged Care Seminar in Osaka

Friday 30 July
- Depart Osaka for Tokyo
- Visit Shinagawa Silver Human Resource Centre

Saturday 31 July and Sunday 1 August
- Rest day

Monday 2 August
- Open the joint Australia-Japan Expert Group meeting under the Australia-Japan Partnership in Health and Family Services
- Meeting with HE Mr Sohei Miyashita, Minister for Health and Welfare

Tuesday 3 August
- Meeting with HE Mr Akira Amari, Minister for Labour
- Host Australian Aged Care Seminar in Tokyo
- Depart Tokyo for Sydney

Wednesday 4 August
- Arrive in Sydney

ITINERARY FOR MINISTER BISHOP'S TRADE MISSION TO SINGAPORE AND MALAYSIA, 11-19 NOVEMBER 2000

Saturday 11 November

- Depart Sydney for Singapore

Sunday 12 November

- Attend the Remembrance Day Ceremony at Kranji War Memorial and lay a wreath

Monday 13 November

- Visit Ren Chi Hospital
- Host Aged Care Capability Seminar in Singapore

Tuesday 14 November

- Visit Siemens Medical Instruments Pty Ltd (hearing aids factory)
- Visit Econ Medicare Centre
- Meeting with Mr Abdullah Tarmugi, Minister for Community Development and Sports
- Meeting with Dr Lee Boon Yang, Minister for Manpower
- Depart Singapore for Kuala Lumpur

Wednesday 15 November

- Meeting with Dato' Chua Jui Meng, Minister for Health
- Host Aged Care Capability Seminar in Kuala Lumpur

Thursday 16 November

- Visit Perbadanan Hal Ehwal Beks Angatan Tentera (PERHEBAT)
- Meeting with YAB Datuk Dr Fong Chan Onn, Minister for Human Resources
- Depart Kuala Lumpur for Penang

Friday 17 November

- Meeting with YB Dato' Dr K Rajapathy, Minister for Health and Welfare, Caring Society
- Host Aged Care Capability Seminar in Penang

Saturday 18 November

- Depart Penang for Singapore

Sunday 19 November

- Depart Singapore for Perth

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS Question: E01000098

Topic: MEDIA MONITORING

Written Question on Notice

Senator Evans asked:

What was the Government's expenditure on media monitoring in relation to aged care in 2000? Indicate the monthly bill for monitoring over the year.

Answer:

The total expenditure on media monitoring in relation to aged care in 2000 was $347,322
The monthly bill over the year was as follows:

January	$5,583
February	$18,857
March	$83,668
April	$59,020
May	$95,243
June	$15,911
July	$8,612
August	$15,368
September	$12,215
October	$11,898
November	$11,538
December	$9,409

ATTACHMENT A

INSTRUMENT TO APPROVE PLACES FOR 2000-2001 (ACA CH2 No. 1/2000)

AGED CARE ACT 1997

Determination Under Subsection 12-3(1)

I, **BRONWYN KATHLEEN BISHOP**, Minister for Aged Care, acting under subsection 12-3(1) of the *Aged Care Act 1997*, **DETERMINE** that for the **2000-2001 financial year** the number of places available for allocation are as set out below.

A) Places available in each State or Territory (to be allocated in regions in the round)

State or Territory	Residential Care Places		Community Care Places
	High Level Care	Low Level Care	
New South Wales	73	2,483	2,237
Victoria	54	2,323	1,623
Queensland	42	398	862
Western Australia	23	455	473
South Australia	17	755	608
Tasmania	4	234	88
Australian Capital Territory	28	50	48
Northern Territory	50	40	124

B) Places available in every State or Territory (the national pool and the contingency pool)

Residential Care Places	High Level Care	Low Level Care	Community Care Places
	100	500[1]	350[1]
Residential Care Places	Both levels of care		
	100[2]		
Flexible Care places	Multipurpose service places		
	MPS high	MPS low	MPS care package
	120	140	25
Flexible Care places	General		
	350[3]		

Note: 1 – For the national pool of places for restructuring
2 - 150 community care places for the national pool for restructuring plus 200 for conversions
3 - For the contingency pool

Dated 23rd day of February 2000

BRONWYN KATHLEEN BISHOP
Minister for Aged Care

Bronwyn Bishop

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 1999-2000, 7 February 2000

OUTCOME 8: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: 72 (a)**

Topic: PUBLIC HOSPITALS – PROVISION OF RESIDENTIAL AGED CARE

Written Question on Notice

Senator Evans asked:

In response to a question (Q 241) from the previous hearing, the Department indicated that in other cases people in public hospitals have been funded by the Commonwealth in lieu of the provision of residential aged care.

Can the Department provide the following information, for the years 1996-97, 1997-98 and 1998-99, on each instance in which people in public hospitals were funded by the Commonwealth while awaiting access to Aged Care Services:

(a) the hospital in which the patients were located;
(b) how many patients were funded by the Commonwealth;
(c) the period over which the patients were funded;
(d) the specific reason why the patients were funded and why the funding was stopped (if relevant).

Answer:

As indicated previously, the Department has on occasions approved the use of approved places in other locations/facilities pending construction of the permanent facility. Strict time limits and conditions have been imposed. The individual information requested would take significant resources away from other essential departmental tasks.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question: E01000160**

Topic: DOCTOR NUMBERS

HANSARD PAGE: CA 83

Senator West asked:

I would appreciate it if you would actually go away and analyse the data, please, to see that in fact we are not bringing in doctors from overseas and we are going to end up with a two-tiered system: doctors who have trained overseas being given permanent residency to come into this country and work in rural and regional areas, and in the cities there will be the Australian trained doctors.

Answer:

The Medicare data available to the Department identifies the place of a doctor's basic qualification but does not allow identification of Medicare activity provided by temporary resident doctors with exemptions granted under section 3J of the *Health Insurance Act 1973* (the Act).

Table 1 shows the number of non-specialist medical practitioners billing Medicare whose basic medical qualification was gained overseas, as compared with those who gained their basic medical qualification in Australia. These numbers include all overseas trained doctors (OTDs), rather than just temporary resident doctors (TRDs) with exemptions granted under section 3J. The proportion of OTDs in metropolitan areas has remained static between 1996-97 and 1999-00. However, over the same period, the proportion of OTDs in rural and remote areas has increased slightly, with a corresponding decrease in Australian trained doctors.

When the services provided by these doctors is considered, a slightly different picture emerges. Between 1996-97 and 1999-00, the proportion of the workload (as measured by full-time workload equivalents, or FWEs) in metropolitan areas provided by OTDs has remained static (Table 2). However, in rural and remote areas there is a small decrease in the proportion of the workload provided by Australian trained doctors, with a corresponding increase for OTDs. It is important to note that more than 75% of services in rural and remote areas continue to be provided by Australian graduates.

Table 3 shows the estimated number of exemptions granted under section 3J of the *Health Insurance Act 1973* (the Act) to allow temporary resident doctors to provide professional services that attract a benefit under the Medicare Benefit Schedule, in rural and remote areas (classified as RRMA 3-7). Comparison of Table 3 with Table 1 would indicate that not all temporary resident doctors granted a 3J exemption may have billed Medicare in 1999-2000.

Under the State and Territory overseas trained doctor recruitment schemes there are currently 79 overseas trained doctors practising in Queensland, Western Australia and Victoria. The scheme is currently being implemented in the other States and the Northern Territory. So far sixteen doctors working on these schemes have been awarded permanent residency or citizenship.

Table 1: Number of non-specialist medical practitioners billing Medicare by place of basic qualifications and type of region[(a)], 1996-97 to 1999-2000

Place of basic qualifications	Type of region	1996-97	1997-98	1998-99	1999-00
Australia					
	Metropolitan				
	Number	14322	13986	13749	13569
	Percent	*75.5*	*75.4*	*76.0*	*75.0*
	Rural & remote				
	Number	4149	4202	4347	4382
	Percent	*74.7*	*73.9*	*73.0*	*71.0*
Overseas					
	Metropolitan				
	Number	4648	4558	4459	4455
	Percent	*24.5*	*24.6*	*24.0*	*25.0*
	Rural & remote				
	Number	1406	1482	1621	1828
	Percent	*25.3*	*26.1*	*27.0*	*29.0*

(a) The region types are defined by grouping region categories as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Table 2: Full-time workload equivalents[(a)] (FWEs) for non-specialist medical practitioners billing Medicare by place of basic qualifications and type of region[(b)],1996-97 to 1999-2000

Place of basic qualifications	Type of region	1996-97	1997-98	1998-99	1999-00
Australia					
	Metropolitan				
	Number	9115	9133	9090	9103
	Percent	*72.1*	*71.6*	*71.4*	*71.3*
	Rural & remote				
	Number	2739	2775	2747	2700
	Percent	*77.1*	*77.1*	*76.7*	*75.3*
Overseas				.	.
	Metropolitan				
	Number	3531	3623	3636	3659
	Percent	*27.9*	*28.4*	*28.6*	*28.7*
	Rural & remote				
	Number	815	822	833	884
	Percent	*22.9*	*22.8*	*23.3*	*24.7*

(a) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners over the reference period ($186,742 for 1999-2000). For example, an FWE value of 2 means their billing was twice the average - ie. $373,484). The FWE values are then added together to produce aggregate numbers for each region.

(b) The region types are defined by grouping region categories as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Table 3: Exemptions under section 3J granted to allow temporary resident doctors to provide professional services under Medicare, in rural and remote areas (RRMAs 3-7)

	Number of exemptions[(a)]	**Number of medical practitioners[(b)]**
1998-99	939	Not available
1999-00	2081	685

(a) The number of exemptions is greater than the number of doctors, reflecting the fact that many of the doctors worked in more than one rural location and some doctors renewed short-term locum exemptions throughout the year.

(b) It should be noted that an additional number of temporary resident doctors work in State and Territory public hospitals and have access to a "class exemption" under section 3J of the Act to refer and prescribe only.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question: E010000161**

Topic: DOCTOR NUMBERS

Hansard Page: CA 85

Senator West asked:

The new figure for 1998-99 of 3,231 FTE GPs working in rural and remote areas is 10 per cent below the figure of 3,563 which was given to me last year on question 233 in the December 1999 estimates. I am going to be comparing apples with oranges here if you do not give me the figures for 1996-97 and 1997-98 on the same basis as the calculation given in the last answer, so we can do a proper comparison.

Answer:

Full Time Equivalent (FTE) GPs were provided in the latest set of data because Question E038-SBE 22 Nov 2000 asked the Department to provide data for 1998-99 and 1999-2000 for the number of GPs and specialists practising in each category of rural and remote area on the basis of full time equivalent doctors. GP workload data is more usually provided as Full Time Workload Equivalents (FWEs), as was requested for Question 233-SBE 1 Dec 1999. The latest FWE figures for GPs are provided in Table 1. The 1998-99 figure provided last year for Question 233-SBE 1 Dec 1999 was 3563. Since then, there has been a minor revision in the underlying data, and the figure for 1998-99 is now 3579 (see Table 1).

Table 1: Full-time workload equivalents[(a)] (FWEs) for non-specialist medical practitioners billing Medicare by region[(b)],1996-97 to 1999-2000

Region	**1996-97**	**1997-98**	**1998-99**	**1999-2000**
Capital city	11380	11464	11446	11476
Other metropolitan centre	1266	1292	1280	1286
Large rural centre	926	946	941	929
Small rural centre	925	930	923	939
Other rural area	1465	1470	1467	1472
Remote centre	116	121	115	112
Other remote area	121	131	133	132
Total rural and remote	*3553*	*3598*	*3579*	*3584*
Total	**16200**	**16353**	**16306**	**16345**

(a) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners during the reference period ($186,742 for 1999-2000). For example, an FWE value of 2 means their billing was twice the average - ie. $373,484). The FWE values are then added together to produce aggregate numbers for each region.

(b) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question: E01000190**

Topic: INCREASED REBATE FOR OMPS

Written Question on Notice:

Senator Evans asked:

(a) What conditions have been applied to the payment of the higher rate of rebate for Other Medical Practitioners in country areas?

(b) Will this apply to any OMP or only those enrolled in the process of registration?

(c) Will the higher rate apply indefinitely or is it subject to adequate progress towards registration?

Answer:

(a) Non-vocationally recognised other medical practitioners (OMPs) who register on the Rural OMPs Program are required to:

- be providing ongoing services in rural and remote Australia (specifically Rural Remote Metropolitan Area classifications 4 – 7); and
- express an interest in and undertake an alternative pathway to vocational recognition.

(b) Only OMPs who register for the Rural OMPs Program and meet the eligibility criteria will receive the higher rebate.

(c) The higher rebate will not apply indefinitely. At such a time that sufficient places are available on alternative pathways OMPs will be required to complete the alternative pathway within four years with an option for a one-year extension to be eligible for the higher rebate.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question No: E01000191**

Topic: MENTAL HEALTH PROGRAMS

Written Question on Notice

Senator Evans asked:

(a) What steps has the department taken to ensure that mental health programs are delivered on time and budgets are properly spent?

(b) What performance indicators have been set for the National mental health program and how is it progressing against those indicators?

(c) Has an independent evaluation been done of the National Mental Health Strategy or the National Suicide Prevention Strategy?

Answer:

(a) Since the commencement of the National Mental Health Strategy in 1993, there has been a need to roll over some funds from one year to the next to achieve the national objectives of the Strategy. The Department has in place a financial plan consistent with the objectives of the current National Mental Health Plan to ensure that all Commonwealth National Mental Health Strategy funds are expended in the year of appropriation.

(b) Under the reform framework of the National Mental Health Strategy (NMHS), the Commonwealth, and State and Territory Governments have agreed to the reporting and collection of specific mental health data, both quantitative and qualitative.

Currently the agreed national performance indicators under the Australian Health Care Agreements are:

- State government recurrent expenditure on mental health services per capita;
- State government recurrent expenditure on community mental health services per capita; and
- inpatient beds in stand alone psychiatric hospitals as a proportion of total designated psychiatric inpatient beds.

The National Mental Health Report 2000 documents the changes made by all Australian jurisdictions under the first five years of the National Mental Health Strategy (1993 to 1998). Progress against these indicators are:

- an increase of 30% in State/Territory spending on mental health services since the commencement of the Strategy.

- increase spending on community mental health care from 29% of specialist mentalhealth spending in 1992-93 to 46% in 1997-98.
- beds in stand alone psychiatric hospitals reduced from 73% to 54% as a proportion of total designated psychiatric beds available in Australia over the 5 year period.

(c) *National Mental Health Strategy*

Yes, an evaluation was undertaken by the Australian Health Ministers Advisory Council titled *Evaluation of the National Mental Health Strategy* (1998) and is available from the Mental Health and Special Programs Branch, Department of Health and Aged Care.

*National Youth Suicide Prevention Strategy (NYSPS***)**

Yes, an evaluation of the NYSPS (1995-1999) was conducted by the Australian Institute of Family Studies and results presented in a report entitled *Valuing Young Lives – Evaluation of the National Youth Suicide Prevention Strategy* (2000) and available from the Mental Health and Special Programs Branch, Department of Health and Aged Care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question No: E01000192**

Topic: BLOOD FUNDING

Written Question on Notice

Senator Evans asked:

(a) Can the Department provide a detailed accounting for how the funds for fresh blood and blood products have been allocated in the budget?

(b) How much does the Commonwealth spend in each State on fresh blood, plasma and blood products?

(c) What does each State spend from its own resources on each of these products?

(d) What volumes of blood were collected in each State in 1999/2000 and how did this compare to the volume of fresh blood and plasma that was utilised in that State?

Answer:

(a) Under current arrangements, the cost of collecting fresh blood and plasma by the Australian Red Cross Blood Service (ARCBS) is shared between the Commonwealth and States/Territories. The Commonwealth contributes 40% of the recurrent costs direct to the respective States and Territories which collectively provides the remaining 60%. The agreed capital costs are shared on a 50:50 basis between the Commonwealth and States. Commonwealth funding is provided under Bill 2 – Blood Transfusion Services. Governments and the ARCBS are party to an annual cycle which decides national priorities for the blood transfusion services.

In terms of processed blood, diagnostic and plasma products, the Commonwealth funds 100% of CSL Limited's costs in fractionating a range of therapeutic plasma products and diagnostic blood products from plasma and red blood cells provided to it by the Australian Red Cross Blood Service. The funding is provided under Special Appropriations National Health Act 1953, Blood Fractionation Products and Blood Related Products.

(b) and (c)

Attachment A provides details of how the Commonwealth's contribution for the collection of blood and plasma by the Australian Red Cross Blood Services was distributed to the State and Territory health authorities in financial years 1999-2000 (actual) and 2000-2001 (budget). As noted each State/Territory funds 60% of the operating costs and 50% of the capital costs of the blood transfusion services. The States and Territories do not contribute to CSL Limited's manufacturing costs.

(d) The ARCBS has provided the State/Territory data at Attachment B on whole blood collections, total plasma to CSL and units of red cells, platelets and fresh frozen plasma issued. The ARCBS does not hold complete and accurate records of the utilisation of fresh blood products for 1999-2000. This information is currently being gathered through audits of hospital inventories and is an on-going process.

Q192
Attachment A

1999/00 Actual Commwealth State Funding towards the ARCBS Blood Transfusion Services

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	TOTAL
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Commonwealth Contribution towards ARCBS recurrent costs	20,320	14,779	11,084	6,774	5,542	1,232	1,232	616	61,579
Commonwealth Contribution towards ARCBS capital costs	1,075	1,642	1,246	1,076	283	226	57	57	5,662
Total Commonwealth Contribution toward ARCBS costs	21,395	16,421	12,330	7,850	5,825	1,458	1,289	673	67,241
State/Territory Contribution towards ARCBS recurrent costs	30,480	22,169	16,626	10,161	8,313	1,848	1,848	924	92,369
State/Territory Contribution towards ARCBS capital costs	1,075	1,642	1,246	1,076	283	226	57	57	5,662
Total State/Territory Contribution towards ARCBS costs	31,555	23,811	17,872	11,237	8,596	2,074	1,905	981	98,031
Total Government contributions to ARCBS	52,950	40,232	30,202	19,087	14,421	3,532	3,194	1,654	165,272

2000/01 Budgeted Commonwealth Funding towards the ARCBS Blood Transfusion Services

	NSW	VIC	QLD	WA	SA	TAS	ACT	NT	TOTAL
	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000	$'000
Commonwealth Contribution towards ARCBS recurrent costs	23,288	16,937	12,702	7,763	6,351	1,411	1,411	706	70,569
Commonwealth Contribution towards ARCBS capital costs	1,350	2,060	1,563	1,350	355	284	71	71	7,104
Additional funding for Hepatits C Virus Litigation claims									6,111
Additional funding for the establishment of a National Managed Fund									588
Additional funding to Increase Donor Recruitment*									1,614
September parameter adjustment									-124
Total Commonwealth Contribution toward ARCBS costs									85,862

*In response to vCJD donor deferral

Question: E01000192
Attachment B

ARCBS 1999/2000 Collection/Issue Data

	Whole Blood Collections	Total Plasma to CSL (KG)	Number Units Red Cells Issued	Number Units Platelets Issued	Number units Clinical FFP Issued
NSW	256,514	63,834	223,396	96,752	59,209
ACT	19,397	4,645	16,411	5,830	1,936
VIC	206,116	56,880	166,370	81,000	34,766
TAS	24,878	7,074	21,740	10,030	1,652
QLD	159,542	46,659	142,142	77,718	22,733
SA	79,349	24,718	64,662	23,305	9,506
WA	77,440	32,001	57,609	30,897	10,221
NT	9,355	2,239	7,890	2,209	1,173
Total	832,591	238,050	700,220	327,741	141,196

Note: The ARCBS does not hold complete and accurate records of the utilisation of fresh blood products for 1999/2000. This information is currently being gathered through audits of hospital inventories and is an on-going process.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4:QUALITY HEALTH CARE **Question No: E01000193**

Topic: BLOOD FUNDING

Written Question on Notice

Senator Evans asked:

(a) What additional funding has the Department provided the ARCBS to upgrade its rural collection facilities to meet the new requirements of the TGA?

(b) Which rural collection facilities have closed in the last 2 years or are at risk of closure because of the cost of upgrading?

(c) What action has the Department taken to prevent closures of Blood collection centres in accordance with the Prime Minister's Nyngan declaration?

Answer:

(a) No additional funding has been provided specifically to upgrade rural collection facilities. At the time the question was asked, the Department had not received the business case compiled by the Australian Red Cross Blood Service (ARCBS) which covers the impact of regulation under Therapeutic Goods Order No 66. When information is received, it will be analysed and discussed with the ARCBS, the Therapeutic Goods Administration and the State and Territory Governments. The Commonwealth will be ensuring that should any extra funding be provided it will be directed to those areas agreed as national priorities.

(b) Therapeutic Goods Order No 66 came into effect in August 2000. Since August 2000, the ARCBS has not advised of any rural collection centres which were closed exclusively due to the costs associated with regulation. The ARCBS takes into account many factors before making a decision to close a facility. These factors include: any conditions on the ARCBS' access to the site; the size of the donor population; attendance rates; collection costs; the availability of alternative services, such as emergency donor panels and mobile collection facilities; as well as regulatory requirements. The ARCBS advises that two centres have been closed since August 2000. Daylesford collection centre in Victoria was closed in December 2000 due to the access to the facility being withdrawn. We are advised that there was no suitable alternative venue and the donor panel was consistently small. We are advised that the Bega collection centre in NSW was also closed in December 2000 due to collection costs, poor attendances and the costs required to enable the centre to meet international standards.

(c) The Prime Minister's Nyngan declaration refers, in part, to a warning system with respect to government decisions involving a reduction in the delivery of an existing Commonwealth service. Under current arrangements the collection of blood is not a Commonwealth service. The collection of blood is funded jointly between the Commonwealth, States and Territories. The Commonwealth's role is to reimburse the States and Territories for part of the costs of their blood transfusion services. Under these arrangements the decision to close collection centres is a decision of the ARCBS. Under current arrangements, neither the Commonwealth nor the State/Territory Governments is required to approve these decisions of the ARCBS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question No: E01000194**

Topic: BLOOD FUNDING

Written Question on Notice

Senator Evans asked:

Can the Department provide a detailed explanation of the contract with CSL and how the $228 million liability to CSL (referred to in the footnote on page 61) has been treated in the budget and how the capital injections referred to will be funded and where this appears in the budget.

Answer:

The Commonwealth entered into a 10.5 year contract with CSL Limited on 23 December 1993 for the manufacture of a specified range of therapeutic plasma products. The contract will expire on 30 June 2004, however there is a Commonwealth option to extend it for a period of up to five years. The major elements of the contract are:

1. CSL can only fractionate plasma provided by the Australian Red Cross Blood Service for the Australian health care system;

2. CSL must at all times remain licensed under the provisions of Part 4 of the Therapeutic Goods ACT 1989;

3. The Commonwealth pays CSL for the products on a two tier pricing structure, where tier one covers fixed costs and tier two covers variable costs. The tier two prices become operative once an agreed threshold level of production is achieved;

4. The Commonwealth approves on an annual basis the quantum and range of products it will fund CSL to manufacture;

5. The contract provides for an indemnity by the Commonwealth to CSL for HIV/AIDS and hepatitis related claims. It also provides that CSL must endeavour to obtain commercial product liability insurance for HIV/AIDS and hepatitis cover, which CSL has been able to achieve;

6. The contract also provides that in the event the level of plasma CSL is able to fractionate in any year falls below a determined minimum level, the Commonwealth guarantees to pay CSL a prescribed amount.

The $228 million liability to CSL reflects the required accounting treatment (in accordance with generally accepted accounting principals) of the arrangement outlined in point 6 above. The liability covers the guaranteed amount for the remainder of the contract period (4 years) and will be reduced annually by $57 million until it is extinguished in 2003/04.

The estimate for the Special Appropriation - National Health Act 1953 - Blood fractionation, products and blood related products, includes provision for the expenses of the CSL contract. Under the accrual budgeting framework the annual expense estimates for the Special Appropriation comprises:

(a) the cash requirement for the payments made to CSL and

(b) the movement in the liabilities between the current and previous financial years. The recognition of the liability removed the expense from the previous estimates.

The capital injections are required to provide sufficient cash to meet the actual payments that will reduce the liability. These will also be funded under the Special Appropriation - National Health Act 1953 - Blood fractionation, products and blood related products.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question: E01000125**

Hansard Page: CA 108

Topic: RAMUS SCHOLARSHIPS

Senator West asked:

I am wanting to know how many offers of RAMUS scholarships have been made for this academic year, how many have been accepted, how many recipients have also received bonded scholarship offer and what has been the pattern in terms of which scholarship people accept?

Answer:

Offers have not yet been made for the Rural Australia Medical Undergraduate Scholarship (RAMUS) Scheme, for the coming academic year. It is anticipated that 80 scholarships will be offered in mid March 2001.

As no offers have been made, no offers have been accepted for RAMUS for the coming academic year.

Students are not permitted to receive both the RAMUS and the Medical Rural Bonded Scholarship. Under the 2001 Guidelines for the RAMUS Scheme, students who are receiving bonded scholarships are not eligible for the RAMUS. On the RAMUS application form students must indicate that they are willing to forfeit any scholarships/bursaries with a value of more than $5,000 per annum to receive the RAMUS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question No: E01000195**

Topic: RAMUS SCHOLARSHIPS ($10,000 PA FOR RURAL RESIDENTS, NO BOND)

Written Question on Notice

Senator West asked:

(a) How many offers for RAMUS scholarships have been made for the coming academic year?

(b) How many have been accepted?

(c) How many RAMUS recipients have also received a Bonded Scholarship offer?

(d) What has been the pattern in terms of which scholarship people accept?

Answer:

These questions were taken on notice at the hearing and have been answered under Question E01000125.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 4: QUALITY HEALTH CARE **Question: E01000196**

Topic: RURAL DOCTOR NUMBERS

Written Question on Notice

Senator Evans asked:

(a) Can the Department confirm that its figures show that there has only been an increase of 55 full time equivalent doctors across RRMA zones 3 to 7 in 1999/2000.

(b) Can the department confirm that against this there has been an increase of 79 in permanent Overseas trained doctors and an approximate 50% increase in the number of temporary Overseas trained doctors up to a figure of 685 doctors (Table 4).

(c) Does this indicate that there is still a net reduction in Australian trained fully registered doctors in rural Australia?

(d) Can you give the figures for 1996/97 and 1997/98 on the same basis of calculation as given in the latest answer to enable proper comparison to previous years?

Answer:

(a) There has been an increase of 55 full time equivalent (FTE) non-specialist medical practitioners billing Medicare in RRMAs 3 to 7 between 1998/99 and 1999/2000 (see Table 1). In the same period, FTEs in metropolitan areas decreased by 27. With the number of non-specialist medical practitioners billing Medicare, there are similar but smaller differences between rural and remote areas as compared with metropolitan areas. Full time workload equivalents (FWEs) have remained static in rural and remote areas, but only increased marginally in metropolitan areas over this period, indicating that service levels have not changed in either rural or metropolitan areas.

Table 1: Number of non-specialist medical practitioners billing Medicare, full-time workload equivalents[(i)] (FWEs) and full-time equivalents[(ii)] (FTEs), by region[(iii)], 1998-99 to 1999-2000

	Total metropolitan		**Total rural & remote**	
	1998-99	**1999-00**	**1998-99**	**1999-00**
Number of GPs	18208	18024	5968	6210
% change		*-1.0*		*4.1*
FWEs	12726	12762	3579	3584
% change		*0.3*		*0.1*
FTEs	10615	10588	3231	3286
% change		*-0.3*		*1.7*

(i) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners during the reference period ($186,742 for 1999/2000). For example, an FWE value of 2 means their billing was twice the average - ie. $373,484). The FWE values are then added together to produce aggregate numbers for each region.

(ii) "FTE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners over the reference period ($186,742 for 1999/2000). The total FTE value for a doctor is then capped at 1, regardless of how busy the doctor is (which has the effect of understating overall Medicare activity). FTEs are counted against each region that doctors record activity during the reference period, rather than just the last quarter of available data.

(iii) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

(b) The Department cannot confirm that, against the FTE increase in part (a), there has been an increase of 79 in permanent overseas trained doctors because the figures are not comparable and pertain to different periods. The 79 are nearly all not permanent; all except ten are temporary resident doctors (TRDs) who only recently commenced on these new State based programs. These doctors were not counted till 7 December 2000, a date well after the period referred to in part (a). As well, they represent a headcount only, and should not be compared directly with FTE figures.

The Department cannot confirm that there has been a 50% increase in TRDs over the period of 1998/99 to 1999/2000. The number of doctors to whom 3J exemptions applied in 1998/99 is not available. As well, the 1999/2000 figure is a headcount only and should not be equated with FTE figures, especially given the commonly intermittent and casual nature of TRD work.

(c) The data do not indicate a net reduction in Australian trained fully registered doctors in rural Australia on its own for the reasons stated above. However, the figures provided in Table 2 below, which pertain solely to doctors billing Medicare, reflect a modest increase in headcount in rural areas of Australian trained doctors over this period, whereas the FWE figure declines marginally. This perhaps reflects doctors working shorter hours, which would therefore offset the increase in actual doctor numbers. It is important to note that more than 75% of services in rural and remote areas continue to be provided by Australian graduates.

Table 2: Number of non-specialist medical practitioners billing Medicare and full-time workload equivalents[(i)] (FWEs), by place of basic qualifications and type of region[(ii)], 1998-99 to 1999-2000

Place of basic qualifications	Type of Region	Number of GPs		FWEs	
		1998-99	1999-00	1998-99	1999-00
Australia	Metropolitan	13749	13569	9090	9103
	Rural & remote	4347	4382	2747	2700
Overseas	Metropolitan	4459	4455	3636	3659
	Rural & remote	1621	1828	833	884

(i) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners over the reference period ($186,742 for 1999/2000). For example, an FWE value of 2 means their billing was twice the average - ie. $373,484). The FWE values are then added together to produce aggregate numbers for each region.

(ii) The region types are defined by grouping region categories as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

(d) FTE GPs were provided in the latest set of data because question E00038 asked the Department to provide data, for 1998/99 and 1999/2000 for the number of GPs and specialists practising in each category of rural and remote area on the basis of full time equivalent doctors. GP workload data is more usually provided as FWEs, as was requested for question 233 in December 1999. The latest FWE figures for GPs are provided in table 3. The 1998/99 figure provided last year for question 233 (in the December 1999 estimates) was 3,563. Since then, there has been a minor revision in the underlying data, and the figure for 1998/1999 is now 3,579 (see Table 3).

Table 3: Full-time workload equivalents[(i)] (FWEs) for non-specialist medical practitioners billing Medicare by region[(ii)],1996-97 to 1999-2000

Region	1996-97	1997-98	1998-99	1999-2000
Capital city	11380	11464	11446	11476
Other metropolitan centre	1266	1292	1280	1286
Large rural centre	926	946	941	929
Small rural centre	925	930	923	939
Other rural area	1465	1470	1467	1472
Remote centre	116	121	115	112
Other remote area	121	131	133	132
Total rural and remote	*3553*	*3598*	*3579*	*3584*
Total	**16200**	**16353**	**16306**	**16345**

(i) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners during the reference period ($186,742 for 1999/2000). For example, an FWE value of 2 means their billing was twice the average - ie. $373,484). The FWE values are then added together to produce aggregate numbers for each region.

(ii) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2001-2002, 19/20 February 2001

OUTCOME 5: RURAL HEALTH **Question: E01000162**

Topic: REGIONAL HEALTH SERVICES

Hansard Page: CA 86

Senator West asked:

I am just interested to know the number of applications and the number of expressions of interest that you might have received that go on to be part of that 48. Is it that you have had 48 applications and 48 have got the tick, or is it 480 that have put their hands up and 48 have got the tick? If so, where have the other ones failed?

Answer:

The Regional Health Services Program has received approximately 245 proposals (including expressions of interest) for primary care services delivery and service planning projects. 50 service delivery projects and 34 service planning projects have been approved.

In many instances approved services are the combining of separate applications covering a single region.

Many proposals have been returned to the applicant for further development.

Approximately 94 proposals have been rejected as they did not meet funding criteria. Most often they have not been able to demonstrate community engagement in identifying need, or are for services or infrastructure outside the scope of the program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2001-2002, 19/20 February 2001

OUTCOME 5: RURAL HEALTH **Question: E01000163**

Topic: RURAL HEALTH COMMUNICATIONS STRATEGY

Hansard Page: CA 87

Senator West asked:

Maybe you can on notice send us a copy of all the sorts of pamphlets and material that you have produced, please, so that I can put my beady eye over it.

Answer:

Please find attached the following material:

- Regional Health Strategy kit cover (Attachment A)
- Rural health newsletter, *Regional Health Check* – issues 1,2 and 3
- A guide to new rural health services (pocket guide size)
- Regional Health Strategy poster
- Regional Health Services Program kit cover [Medical Specialist Outreach Assistance Program] (Attachment B)
- Brochure on the Regional Health Services Program
- A guide to the Regional Health Services Program
- Regional Health Services Program poster

[Note: attachments have not been included in electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 5: RURAL HEALTH **Question No: E01000164**

Topic: MULTI PURPOSE SERVICES

Hansard Page: CA 88

Senator West asked:

Maybe you can give me a breakdown of where they are and what stages they are at. Perhaps that could go on notice too. Have there been any changes in the administration or regulations regarding the administration of MPSs?

Answer:

The list at Attachment A provides a breakdown of all Multipurpose Services by State/ Territory and identifies whether they are operational or not.

There have been no substantive changes in the administration or regulation of the program. However, the Department will continue to look at ways to improve implementation of the MPS initiative through working closely with providers and State/Territory health departments.

E01000164 Attachment A

APPROVED MULTIPURPOSE SERVICES

State	Approved and Operational	Approved but not yet Operational
NSW	Baradine	Oberon
	Urana	Wilcannia
	Urbenville	Lake Cargelligo
	Braidwood	Boggabri
	Delegate	Holbrook
	Dorrigo	
	Tumbarumba	
	Warren	
	Culcairn	
	Trangie	
	Trundle	
VIC	Corryong	
	Orbost	
	Apollo	
	Timboon	
	Mallee	
	Robinvale	
	Alpine	
QLD	Clermont	Barcaldine
	Cooktown	Springsure
	Dirranbandi	Taroom
	Quilpie	Woorabinda
	Mundubbera	
	Inglewood	
	Mossman	
	Texas	
SA	Eyre Peninsular	Eastern Eyre
	Ceduna/Yalata	
	Nganampa	
	Kangaroo Island	

WA	Dalwallinu	Onslow
	Boyup Brook	Moora
	Northampton/Kalb	Morawa/Perenjori
	Katanning	
	Leonora/Laverton	
	Murchison	
	Eastern Wheatbelt	
	York	
	Denmark	
	Kondinin	
	Lake Grace	
	Ravensthorpe	
	Norseman	
	Cunderdin	
	Augusta	
	North Midlands	
	Beverley	
	Dongara/Mingenew/Eneabba	
	Pemberton	
	Wongan Hills	
TAS	Beaconsfield	Campbell Town
		Tasman
NT	Belyuen	

PROPOSED MODELS AND LOCATIONS FOR NEW RURAL CLINICAL SCHOOLS AND UNIVERSITY DEPARTMENTS OF RURAL HEALTH

Proposed New Rural Clinical Schools

Title	University	Location
1. Coffs Harbour Rural Clinical School	UNSW	New node of Wagga Wagga Rural Clinical School based at Coffs Harbour, extending to Port Macquarie and surrounds.
2. Dubbo Rural Clinical School	Sydney University	Mid-west NSW, based at Dubbo, extending to Broken Hill, Orange, and the surrounding districts.
3. Rockhampton/Toowoomba Rural Clinical School	University of Queensland	Rockhampton, Toowoomba, Longreach and surrounding districts.
4. Kalgoorlie Rural Clinical School	University of Western Australia	Based at Kalgoorlie- - 1st stage: Kalgoorlie, Geraldton; - 2nd stage: Albany, Bunbury, Busselton.
5. Riverland/NT Rural Clinical School	Flinders University	Riverland, Adelaide Hills/Mallee region, South east region (Mt Gambier), Fleurieu Region, Darwin, Alice Springs, Gove, Katherine.
6. Bairnsdale Rural Clinical School	Monash University	Based at Bairnsdale, extending to Gippsland, Bendigo, Mildura, Traralgon, Latrobe, Sale, Warragul, Loddon-Mallee regions and surrounding districts.
7. Shepparton Rural Clinical School/UDRH	University of Melbourne	Based at Shepparton with a node established at Ballarat, extending to Wangaratta, Bendigo, Warrnambool, Horsham, Benalla, Echuca and surrounding districts.
8. Whyalla Rural Clinical School/UDRH	Adelaide University	Spencer Gulf region, Eyre and Yorke Peninsulas, including Whyalla, Port Augusta, Port Pirie, Coober Pedy, Port Lincoln and surrounding districts.
9. Burnie Rural Clinical School	University of Tasmania	North West Tasmania, based at Burnie, extending to Latrobe, Smithton, Rosebery, Queenstown, King Island and surrounding districts.

Proposed New University Departments of Rural Health

Title	University	Location
1. Tamworth UDRH	Newcastle University	Based at Tamworth and surrounding areas.
2. Lismore UDRH	Sydney University in collaboration with Southern Cross University	Based at Lismore, extending to Tweed Heads, Grafton, Moree, Walgett and surrounding districts.

Additional funding will be made available to James Cook University in later years to develop clinical placements in Northern Queensland.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000 - 2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E01000266**

Topic: TERMS OF REFERENCE FOR THE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH COUNCIL

Hansard Page: CA 89

Senator Evans asked:

To provide the exact wording of the first Term of Reference for the National Aboriginal and Torres Strait Islander Health Council.

Answer:

The first Term of Reference asks the council to:

- advise on a national strategy to take Aboriginal and Torres Strait Islander health into the twenty first century, drawing on existing reports including the 1989 National Aboriginal Health Strategy, the 1998 Australian National Audit Office Performance Audit of the Aboriginal and Torres Strait Islander Health Program and on the report of the House of Representatives Standing Committee on Family and Community Affairs inquiry into Indigenous Health, when it becomes available;

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E01000135**

Topic: NACCHO

Hansard Page: CA91

Senator Evans asked:

(a) Funding for National Aboriginal Community Controlled Health Organisation (NACCHO) - Secretariat support - total amount.

(b) Funding for Secretariat and project officers for the Indigenous Doctors Association and the Indigenous Nurses Association - the final amount.

Answer:

(a) During 2000-2001 a total of $2,279,340 is being provided to the National Aboriginal Community Controlled Health Organisation (NACCHO). This includes $622,850 for secretariat and operational support, $1,141,530 for policy officers, and $514,960 for other projects and consultancies.

(b) In 1999-2000, the Department provided $62,500 to the Australian Indigenous Doctors Association (AIDA) and $66,500 to the Congress of Aboriginal and Torres Strait Islander Nurses (CATSIN). No funds have been applied for as yet during 2000-2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E1000136**

Topic: INDIGENOUS RENAL DIALYSIS UNITS

Hansard page: CA 92

Senator Evans asked:

Current progress report on the Indigenous renal dialysis units in the Kimberley and Cape York

Answer:

Kimberley, Western Australia

The Commonwealth and the Health Department of WA have agreed and approved plans for a ten- bay dialysis centre to be located at the Broome Aboriginal Medical Service site.

The Commonwealth will provide one off matched capital funding of up to $500,000 towards the development of the renal centre. The Health Department of WA has recently undertaken a comprehensive assessment of the costs associated with the renal centre and will provide recurrent operational funding for the service.

A single bay facility will also be placed in the Broome hospital providing capacity for acute dialysis where high-level care is required.

It is anticipated that building of the renal centre will commence in the next few months and will be operational by the end of June 2002.

Cape York, Queensland

There has been agreement between the Commonwealth and Queensland Health that Commonwealth funding of up to $1 million will be used for capital infrastructure for the establishment of a prevention service, a limited haemodialysis unit at Weipa and a haemodialysis unit at Bamaga.

The decision to place the renal units at Weipa and Bamaga has been a lengthy process. It has been informed by a consultancy commissioned by Queensland Health and completed in February 2000 to develop a renal services plan for the Queensland Northern Zone geographical area.

Architectural plans for construction and refurbishment of the two renal units have been approved by Queensland Health. The units should be completed within 6 months depending on seasonal conditions.

There will be 2-4 chairs at Weipa, located within the hospital. At Bamaga, agreement has been reached with Torres Strait Islander Board and the local community to establish 4 chairs within the Bamaga Hospital.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E01000137**

Topic: DENTAL FACILITIES

Hansard Page: CA 93

Senator Evans asked:

Number of dental facilities in the Commonwealth funded Aboriginal health services.

Answer:

Commonwealth funded Aboriginal health services receive funding for comprehensive primary health care and data is not available separately on dental facilities within these services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E01000197**

Topic: DENTAL SERVICES IN ABORIGINAL HEALTH SERVICES

Written Question on Notice

Senator Evans asked:

(a) How many dental facilities are in Commonwealth funded Aboriginal Health Services and how many of these are not in use?

(b) Where are these services located and what is the reason for the facilities not being used?

(c) Does the Office for Aboriginal and Torres Strait Islander Health provide funding for dental services? If not why were the facilities built and how are they expected to operate without funding?

Answer:

(a) The provision of public dental services is a state and territory responsibility. The Commonwealth does not have data specifically on dental facilities within Commonwealth funded Aboriginal health services.

(b) As above.

(c) At the time of transfer of Aboriginal Community Controlled Health Services (ACCHS) from the Aboriginal and Torres Strait Islander Commission (ATSIC) to the Health portfolio in 1995, the funding for some ACCHSs included a component for dental services. The Office for Aboriginal and Torres Strait Islander Health has maintained the agreed level of funding for those ACCHSs. The services can decide whether to maintain a dental service according to their own priorities and needs.

OATSIH also continues to support pre-transfer dental services in the replacement and maintenance of dental equipment. This is funded on a case-by-case basis in the context of overall infrastructure refurbishment needs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH. Question: E01000138

Topic: ATSIC/ARMY COMMUNITY ASSISTANCE PROGRAM (AACAP)

Hansard Page: CA 93

Senator Evans asked:

AACAP program – which communities will be serviced and when in the second stage?

Answer:

First stage two AACAP projects were located in the Northern Territory, on the Tiwi Islands (Milikapati and Wurankuwu). They were completed in 2000.

For year 2001 two further projects in the Northern Territory have been selected: Yarralin/Lingara and Amanbindji (both west of Katherine).

Further projects in 2002 are likely to be located in Western Australia and in 2003 in Queensland. Actual sites are being explored in these jurisdictions and are yet to be considered by the Steering Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E01000199**

Topic: ATSIC/ARMY COMMUNITY ASSISTANCE PROGRAM (AACAP)

Written Question on Notice

Senator Evans asked:

(a) Can you please provide a full statement of the actual and anticipated spending under the original proposed cash flow and how it will occur under the revised cashflow.

(b) Can you please provide the breakdown of spending between the Army and private contractors and how this is intended to be divided in future?

Answer:

(a) $40 million is available for stage two AACAP projects over six years from 1999/2000. This includes $20 million provided in the 1999/2000 budget through the Department of Health and Aged Care, and an additional $20 million being contributed by ATSIC.

Originally, the same amount was available over four years from 1999/2000 (ie, a notional allocation of $10 million per year).

To date, some $15 million has been committed (including projects planned for construction in 2001). It is anticipated that up to $10 million may be committed for projects planned for 2002. The remaining $15 million would then be allocated across the remaining three years (2003 – 2005), at a notional $5 million a year. These estimates may vary and will be subject to adjustment in line with the size, scope and progress of individual projects.

	1999-00	2000-01	2001-02	2002-03	2003-04	2004-05
Original	$10m	$10m	$10m	$10m	NIL	NIL
Revised	$5.3m	$9.5m	$10m	$5.2m	$5m	$5m

(b) Decisions about the use of private contractors are made on the project by project basis, depending on each project's scope, relative merits and availability of using Army personnel and contractors. Therefore, there is no pre-determined break up of allocation between Army and private contractors.

Private contractors were used in both recently completed NT projects, and will be used in the two projects about to commence. For these, some 35% of the overall expenditure is anticipated to be for private contractors.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E01000139**

Topic: FRAMEWORK AGREEMENTS

Hansard Page: CA 26

Senator Crowley asked:

Mr Podger, would it be possible to provide me with a copy of the framework agreements?

Answer:

Framework Agreements attached.

[Note: attachments have not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E1000198**

Topic: RENAL DIALYSIS

Written Question on Notice

Senator Evans asked:

(a) How many people have died from renal failure in the last two years in ( ) Kimberley and Pilbara and ( ) Cape York

(b) How many people have been diagnosed as in need of renal dialysis in the last two years in ( ) Kimberley and Pilbara and ( ) Cape York.

Answer:

(a) The following data has been provided by the Australian Bureau of Statistics (ABS). This data needs to be viewed cautiously as the level of identifications of Aboriginal and Torres Strait Islander people is quite variable. As the number of deaths is quite small data has been aggregated on a regional basis and the years 1998 and 1999 combined to protect the privacy of individuals. The death rates are based on 1996 Census population data.

( ) In the Kimberley and Pilbara regions 6 Indigenous people have died from renal failure as the underlying cause of death in 1998-1999. The data for Non-Indigenous people has not been released by the ABS. (ABS data is not published for reasons of confidentiality where it is likely to enable the identification of a particular person or organisation - *Census Statistics Act 1905, section 12(2*). This requirement has been applied by ABS in this case, as in this particular region the non-Indigenous population is so much smaller than the Indigenous Population.)

In addition, 44 Indigenous people and 10 Non-Indigenous people have died with renal failure contributing to their death. That is, renal failure was one of several contributing causes of death. The death rate for Indigenous people is more than 14 times the Non-Indigenous rate.

( ) In Far North Queensland 7 Indigenous and 9 Non-Indigenous people have died from renal failure as the underlying cause of death in 1998-1999. The death rate for Indigenous people is more than 5 times the Non-Indigenous rate.

In addition, 57 Indigenous and 117 Non-Indigenous people have died with renal failure contributing to their death. That is, renal failure was one of several contributing causes of death. The death rate for Indigenous people is 4 times the Non-Indigenous rate.

(b) ( ) For Kimberley and Pilbara regions, the only information indicating the number of Indigenous people diagnosed as in need of renal dialysis is based on separations from hospital. The following information was supplied by the Health Information Centre, Health Department of WA.

Financial Year	Indigenous People hospitalised for dialysis
1998/1999	93
1999/2000	71
Total	164

This may be an undercount of the number of people with end stage renal disease because some may not have been hospitalised.

( ) Data from the Cape York region indicating the number of Indigenous people diagnosed as in need of renal dialysis, report 33 patients with end stage renal disease for the 7 year period, 1993-99. These data were supplied by the Cairns Health Service District Renal Unit, Queensland Health. Breakdown by year was not available.

HON DR M WOOLDRIDGE

National Aboriginal Community Controlled
Health Organisation
ABN 89 078 949 710

The Hon Dr Michael Wooldridge
Minister for Health & Aged Care
Parliament House
Canberra ACT 2600

Dear Minister Wooldridge

I refer to your Department's letter of 29 November 2000 regarding the review of the National Aboriginal Health Strategy 1989 (NAHS).

First of all I must dispute your Secretary's claim in that letter that NACCHO members present at the Health Council meeting of 20 October 2000 agreed that subject to minor amendments the draft could be sent out for consultation. Our members were given no real option and their perception was that the distribution of the consultation draft was presented as a fait accompli

In regard to more substantive issues, as you may be aware, NACCHO representatives from around Australia have been meeting in Geelong this week for our Annual General Meeting and Conference. The Revision of the NAHS has caused much concern and debate among our members. The outcome has been a strong endorsement of the view conveyed in our letter of 14 November 2000 that the current draft of the document must be rejected outright as entirely unacceptable.

As outlined in our letter, the Consultation Draft contains much that is offensive to Aboriginal peoples, particularly those sections referring to the Stolen Generations and other aspects of Aboriginal history. It fails to support Aboriginal self-determination and community controlled health services. In addition, both the process by which the draft was produced, and the proposed consultation process, is inconsistent with Aboriginal self determination which we know is essential to the improvement of Aboriginal health.

You will be aware that NACCHO had major reservations about the restructuring of the National Aboriginal and Torres Strait Islander Health Council and only agreed to participate in the Council under duress. The reduced role of NACCHO on the Council has significantly diminished the voice of the community controlled sector in important deliberations such as the NAHS review.

This has resulted in a product irretrievably inferior to the 1989 NAHS. This is the result of its flawed structure and process in that the draft does not affirm the right of Aboriginal communities to control their own health. Therefore, I wish to inform you NACCHO is withdrawing its representation from the National Aboriginal and Torres Strait Islander Health Council effective immediately.

We do however acknowledge that the original reasons which prompted a review of the NAHS (1989) still exist. That is, we believe the document should be reviewed, updated where necessary and an assessment made of its implementation to date. In order to progress this goal, NACCHO proposes that the Aboriginal community controlled health sector revise the 1989 NAHS through NACCHO in conjunction with state and territory Affiliates along with state and territory Aboriginal Health Forums (under the Framework Agreements).

I will be approaching the Secretary of your Department, Mr Andrew Podger, in relation to securing funding to support this process.

I request that a copy of this correspondence be forward to members of the National Aboriginal and Islander Health Council.

Yours sincerely

Henry Councillor
Annual General Meeting Chairperson 2000

7 December 2000

The Hon Dr Michael Wooldridge
Minister for Health and Aged Care

Mr Arnold Hunter
Chairperson
National Aboriginal and Torres Strait Islander Health Organisation
PO Box 168
DEAKIN WEST ACT

Dear Mr ~~Hunter~~ Rugby,

I am writing in response to the letter I received from Mr Henry Councillor, NACCHO Annual General Meeting Chairperson, on 7th December 2000. Mr Councillor advised me that NACCHO was withdrawing its representation from the National Aboriginal and Torres Strait Islander Health Council effective immediately because NACCHO considered the consultative draft of the National Aboriginal and Torres Strait Islander Health Strategy prepared by the Council to be offensive to Aboriginal people and unacceptable.

It is with disappointment and regret that I accept the withdrawal of NACCHO's representatives from Council. At a time when there is so much support for the National Reconciliation Council's blueprint for close collaboration between Governments and the community sector to improve outcomes for Indigenous peoples, it is sad that NACCHO have chosen to take a different path.

A long term, partnership-based approach between governments and the community sector has been recognised as fundamental to achieving sustainable gains in health status for Indigenous Australians and it remains the approach to which I am wholeheartedly committed. I intend to continue to work with community-based organisations and individual Aboriginal Medical Services that wish to work in a collaborative way to support improvements in Indigenous health.

I was very surprised to read Mr Councillor's comments on behalf of NACCHO regarding the development of the National Strategy. NACCHO representatives on Council have been closely involved in the drafting and development process since it commenced 16 months ago. At its October 2000 meeting all Health Council members were asked if they supported the draft document being released for a six-month public consultation process and all members agreed. Notwithstanding this, when for the first time NACCHO expressed its concerns in writing, Mr Podger agreed to delay releasing the draft to allow Council time to discuss NACCHO's concerns.

Suite MG 48 Parliament House Canberra ACT 1600 Telephone (02) 6277 7220 Facsimile (02) 6273 4146

In light of this it is bewildering that NACCHO have walked away from the Council at a time when every opportunity was being provided to all Council members to consider and work through NACCHO's concerns. It is difficult to know what more could have been done to involve NACCHO and incorporate NACCHO's perspective within a document developed through the partnership arrangements agreed at the outset.

I can only conclude that NACCHO is not willing to accept the responsibilities that go with a genuinely collaborative approach and that its actions reflect some separate agenda.

I have asked the Council to continue its development of the Strategy so that it can be put to the various governments and to ATSIC and the broader community sectors for consultation and endorsement. While NACCHO's presence will be missed, the Council will continue its vital work of advising government on how best to improve the health of Aboriginal and Torres Strait Islander peoples and, drawing on the expertise of the Aboriginal and Torres Strait Islander members of Council, will consider ways to canvass and consider Aboriginal community controlled perspectives in its activities.

In light of NACCHO's resignation from Council and the growing number of Aboriginal Medical Services who have chosen to withdraw from membership of NACCHO I believe the current arrangements between the Commonwealth and NACCHO have become untenable. I am therefore writing to advise you that I have asked OATSIH to consider the extent and adequacy of the coverage of the current national representation arrangements. In doing this, I have asked OATSIH to consult with a wide range of bodies involved in Aboriginal health including community controlled services, state/territory based representation bodies, substance misuse services, indigenous doctors, nurses and health workers and ATSIC as to what the best national representation arrangements might be. In this context I should advise you that I cannot guarantee continuing direct Commonwealth funding for NACCHO at the end of this process and ask you to make arrangements for the organisation accordingly. To help you however, I will guarantee present arrangements until 30 June, 2001.

In instigating this process I want to assure you that I am committed to maintaining, at a minimum, the same level of funding for national representation services that is currently provided. However, to which body or bodies this funding might be provided will be considered in light of these consultations.

I hope that NACCHO will participate in the consultation process and work with all bodies to ensure the best outcomes for Aboriginal and Torres Strait Islander health as this is, I believe, the primary objective in all our efforts.

Yours sincerely

Michael Wooldridge.

Dr Michael Wooldridge

21/12/2000.

...riginal Community Controlled
Health Organisation
ABN 89 078 949 710

M01 001423

The Hon. Dr Michael Wooldridge
Minister For Health and Aged Care
Parliament House
CANBERRA ACT 2601

Dear Dr Wooldridge

I am writing to advise you of the NACCHO Board's decision regarding discussions between NACCHO representatives and the Secretary of your Department at a meeting in Adelaide on 15 January 2001.

As confirmed in my letter of 30 January to Mr Podger, the points formulated at that meeting were:

- clarification that the revised National Aboriginal Health Strategy is at this stage for consultation only, not for endorsement;
- recognition that all parties will have opportunities to address concerns through the consultation process; and
- agreement on the need for an updated strategy that is widely endorsed and can attract the commitment of all governments.

The Board has accepted these points and reconsidered the current situation in that context. At the next meeting of members, the Board will therefore propose that the resolution withdrawing NACCHO membership from the Health Council be rescinded. In the meantime, the Board has agreed to cooperate with the consultations on the Strategy, and to seek your agreement to return to the Health Council.

On this basis, I look forward to re-establishing a productive working relationship as soon as possible. As we discussed at the Adelaide meeting, it would be desirable to have NACCHO representatives attend the next meeting of the Health Council, which I understand is to be held in the week beginning 5 February.

ACN 078 949 710

I think it would be also be very useful if you and I were to meet with a view to resolving any other outstanding issues or concerns. I will be in Canberra from next Wednesday, 7 February until Friday 9 February and if your schedule allows, would very much appreciate the opportunity to meet with you during that time.

Yours sincerely

Puggy Hunter
Chairperson

* February 2001

CC – Mr Andrew Podger
Secretary
Department of Health & Aged Care

Ms Helen Evans
First Assistant Secretary
OATSIH

The Hon Dr Michael Wooldridge
Minister for Health and Aged Care

Mr Arnold Hunter
Chairperson
National Aboriginal Community Controlled Health Organisation
PO Box 168
DEAKIN WEST ACT 2601

Dear Puggy

I am writing in response to your letter of 1 February, 2001 regarding NACCHO's role in the National Aboriginal and Torres Strait Islander Health Council (NATSIHC).

As I understand it was concerns related to the draft strategy document and process that prompted NACCHO's decision to withdraw from the Council I welcome the Board clarifying its understanding of issues related to the development of a new National Aboriginal and Torres Strait Islander Health Strategy, specifically:

- that the revised strategy document is, at this stage, a draft for consultation only and not for endorsement
- recognition that all parties will have opportunities to address concerns through the consultation process; and
- agreement on the need for an updated strategy that is widely endorsed and can attract the commitment of all governments and parties.

Although I remain concerned that there was ever any misunderstanding regarding the draft Strategy I trust that your members are now clear on these points and the planned processes related to the consultation phase of the Strategy's development.

I acknowledge your request for my agreement for NACCHO to return to the NATSIHC. While I note this is a decision of the Board and that the motion of the NACCHO AGM is not rescinded, I am willing to agree to this at this time. I agree that it would be useful for NACCHO representatives to attend the meeting on 9 February and will ask that you receive details and papers as soon as possible.

Unfortunately I will not be able to meet with you this week. This is a short sitting week, the first of the year, and my program is quite literally full. I would be happy to meet with you when I am next in Canberra and ask that you contact June Van Opstal in my office about arranging a suitable time for both of us.

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HON DR M WOOLDRIDGE

I appreciate NACCHO's efforts to re-establish a productive working relationship. While I welcome NACCHO's request to return to the NATIHC I must be clear that OATSIH will continue with the consultation process related to the extent and adequacy of the coverage of the current national representation arrangements. I look forward to discussing this and other issues with you when we meet.

Yours sincerely

Michael Wooldridge

Dr Michael Wooldridge

06 FEB 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E01000263**

Topic: BUSH NURSING, SMALL COMMUNITIES AND REGIONAL PRIVATE HOSPITALS PROGRAM (BNSC&RPH)

Hansard Page: CA 87

Senator West asked:

The Bush Nursing, Small Communities and Regional Private Hospitals Program, $30.3 million over four years 'to assist community hospitals in rural areas to identify the need for and implement refurbishment or reorganisation, business re-engineering or restructuring': I would like a bit of a progress report on what is happening with that.

Answer:

With respect to progress of this initiative in New South Wales, we are due to visit 6 private hospitals, these are; Dubbo, Yeoval, Orange, Bathurst, Lithgow and Wagga Wagga. It is intended to complete preliminary visits of the other 8 targeted hospitals by June 2001. These initial visits are the first step towards service planning made available under the BNSC&RPH.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000119

Topic: 30% REBATE

Hansard Page: CA 95

Senator Collins asked:

What proportion of your total outlay in relation to the 30 per cent rebate would take into account people with ancillary benefits?

Answer:

Based on contribution income receivable as reported in the Private Health Insurance Administration Council Annual Report 1999-2000, Operations of the Registered Health Benefits Organisations, the proportion of the total cost of the Rebate attributable to contribution income from ancillary tables (including ambulance only tables) is estimated to be approximately 29%.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E01000120**

Topic: ANCILLARY BENEFITS

Hansard Page: CA 96

Senator Collins asked:

I am curious whether you have looked at this issue in terms of future forecasting in relation to ancillary services. I note from my own experience – yesterday or the day before – Australian Unity is now advertising not only ambulance-type extra cover but after-care products such as home help, child care and I think the ad said 'even child care'. I am curious whether the department has done any work on a potential blow-out in relation to ancillary benefits?

Answer:

Australian Unity does not offer after-care products under its ancillary tables. Australian Unity does offer a Member Support Program which provides care in the home for members with hospital cover who, with the support of their doctor, have elected to leave hospital early to continue their recovery after surgery or childbirth in their own home. This program provides consumers with choice regarding the delivery of their care.

The decision to leave hospital early and access these services is made by the patient and their doctor. All services provided under this program are those deemed necessary by the member's doctor and can include childcare. All services are funded by benefits that would have otherwise have been paid to the hospital to cover the patient's extended hospital stay.

The Federal Government's 30% Rebate contributes 30% to the costs of consumers' private health insurance premiums, rather than 30% to the cost of the benefits paid out by a health fund. The Department has therefore monitored any changes in the cost of health insurance contributions and over the past 2 years the average premium increases for private health insurance have been very small.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E01000121**

Topic: AMBULANCE SERVICE COVER

Hansard Page: CA 96

Senator Collins asked:

(a) Are you aware of a move by the health funds away from rebating subscriptions to reimbursing emergency ambulance services, apart from one complaint?

(b) Were the Victorian, South Australian and Queensland ambulance services told that they were precluded from access to the Federal Government's 30 % Rebate by the Commonwealth-State agreement?

(c) Are some health funds such as AXA creating a disadvantage for State and Territory Governments in the way they provide ambulance cover?

(d) What information is available from the Ombudsman in relation to consumers' experience of ambulance cover and specifically with Medibank Private's ambulance cover?

Answer:

(a) Funds have for many years offered products that have provided a range of different ambulance cover, including options such as emergency only ambulance cover, full ambulance cover, and refunding members' ambulance subscriptions. Seven funds also offer as a product, an ambulance only ancillary table**.** There is no evidence to suggest that health funds have significantly altered their ambulance products since the introduction of the Federal Government's 30 % Rebate.

The arrangements in relation to ambulance cover differ markedly from State to State. For example since 1984, New South Wales (NSW) has had in place an ambulance levy (under the *Health Insurance Levies Act 1982*) that applies to all health funds providing health benefits to their contributors who reside in NSW. NSW privately insured residents who hold a hospital table are automatically covered for ambulance transport and therefore do not need to subscribe to the NSW Ambulance Plan or take out specific ancillary ambulance cover. In NSW, residents without private health insurance can join the State Ambulance Insurance Plan at the branches of three health funds who act as the agents for the Ambulance Service of NSW.

The Australian Capital Territory (ACT) introduced similar legislation to NSW under the *Ambulance Service Levy Act 1990.* ACT residents with private health insurance hospital tables are automatically covered for ambulance transport as a mandatory part

of their private health insurance. If they choose, ACT residents without private health insurance can join the ACT Ambulance Service insurance scheme at branches of one health fund that acts as an agent.

In Western Australia, the health fund, Hospital Benefits Fund (HBF), has been operating the St John ambulance subscription scheme for the Perth metropolitan area since 1998. In Tasmania, ambulance services are free to all resident Tasmanians.

(b) The funding, policy and implementation of ambulance services is an individual State or Territory responsibility and falls outside the scope of the Australian Health Care Agreements.

Department representatives met with representatives of State Ambulance Services in February 1999, at the request of the Australian Convention of Ambulance Authorities, to discuss the feasibility of ambulance subscription schemes becoming registered health funds so that their schemes would qualify for the Federal Government's 30 % Rebate. Members of the Convention are both insurers and, providers of ambulance services, and as they are not registered health funds their subscribers cannot claim the Federal Government's 30 % Rebate.

The representatives of the Convention were provided with a range of options to gain acceptance to the Federal Government's 30 % Rebate program including:

I. becoming a registered health fund;
II. Convention members amalgamating with one of the current registered health fund/s; or
III. contracting their health insurance business to current registered health fund/s (such as HBF operating the subscription scheme on behalf of the St John's ambulance subscription scheme in WA).

The Department was subsequently advised that the Convention members had met and decided that, as their administrative and other arrangements differ markedly, they would pursue their own directions on this issue.

Subsequently, in November 2000 the South Australian Ambulance Service (SAAS) met with the Department to discuss a proposal to transfer its ambulance cover to a registered health fund. However the SAAS advised the Department on 5 January 2001 that the South Australian Government had not approved the arrangement and therefore 'the product will remain with the SAAS for the forseeable future'.

(c) AXA health fund provides ambulance cover as part of its ancillary and hospital tables and as a stand-alone product. These arrangements have been in place since 1995 when AXA introduced 'Under 50' and 'Over 50' hospital tables. The Over 50 table reimburses ambulance subscription cover, while the Under 50 table provides benefits on a trip refund basis. AXA has advised that these arrangements were introduced based on the preference of their older members to retain their ambulance subscription cover, and that consumers are free to select whichever table they regard as most appropriate to their needs, regardless of their age, in line with community rating requirements.

(d) There is no indication from the Private Health Insurance Ombudsman (PHIO) that the provision of ambulance cover by health funds is an issue of concern to consumers. PHIO receive on average two complaints per month relating to ambulance cover. These complaints are evenly distributed between the States, and according to PHIO 'there has been no discernible increase in the number of complaints in this area since the introduction of Lifetime Health Cover'.

Consumers have a choice in determining the level of ambulance cover that best meets their individual needs. Consumers can subscribe directly to a State/Territory ambulance insurance scheme or they can choose from various levels of ambulance cover that have been offered for many years by registered health funds (see answer to question (a) for more information regarding the level of ambulance health fund coverage).

Medibank Private has provided the following response to Senator Collins's question.

"Medibank Private in Victoria has included ambulance transportation cover in its hospital and ancillary tables from as far back as the early 1990's. Up until 1996, this cover was for immediately necessary or emergency transportation.

In 1996, Medibank Private introduced a stand-alone ambulance cover as a low cost entry-level health insurance product. This product provides 100% cover for any ambulance transportation where the patient's medical condition warrants the use of an ambulance to transport them. This includes non-emergency as well as emergency transport. This table also covers circumstances where a patient wishes to be transferred to a hospital closer to home and charges raised by an ambulance service where a call-out has been made but the patient does not subsequently require transportation.

The ambulance transport cover under the hospital and ancillary table was extended to mirror the cover available under the stand alone table following that table's introduction. This comprehensive level ambulance cover has been included in every new hospital and ancillary product introduced by Medibank Private since 1998.

Medibank Private has not specifically marketed ambulance cover, either as part of another product or the stand alone product in Victoria for a number of years."

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH ..... Question: E01000202

Topic: AMBULANCE COVER

Written Question on Notice

Senator Evans asked:

(a) What is the value of health insurance policies for ambulance only cover for which the 30% rebate is paid?

(b) How much was paid out by health insurance funds in benefits for ambulance expenses from policies of all types?

(c) How much was paid out as reimbursement of ambulance membership fees?

Answer:

(a) The value of contributions from ambulance only products for which the 30% rebate is paid was $20.565 million in the 1999-2000 financial year. This is based on data published by the Private Health Insurance Administration Council (PHIAC) in its 1999-2000 Annual Report titled 'Operations of the Registered Health Benefits Organisations'.

(c) The value of ambulance benefits paid out by health funds under all ancillary products during the 1999-2000 financial year was $20.459 million. This figure, which is also published in PHIAC's 1999-2000 Annual Report, reflects ambulance benefits paid from health funds' *ancillary tables* for non-contractual services.

Explanatory note: Ambulance only products fall within the broader category of ancillary products offered by health funds. The response to (a) above relates to health funds' contributions from ambulance only products while the response to (b) relates to health funds' expenses for ambulance only products and ambulance products that are part of other ancillary products.

Under some ambulance products health funds cover the cost of ambulance subscription schemes, while under other ambulance products the funds cover the benefits paid for the use of ambulance services.

(d) PHIAC advises that it cannot identify the amount paid by health funds for the reimbursement of ambulance membership fees (ie ambulance subscription schemes). According to PHIAC however this amount is likely to be included in the amount of $20.459 million paid by health funds from ancillary products for ambulance cover in 1999-2000 (refer (b) above).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000122

Topic: CHANGES TO PRODUCTS

Hansard Page: CA 98, CA99

Senator Evans asked:

Have you got any figures on the prevalence of these products and of hospital only cover? Are you able to, for instance, track since the rebate came in what percentage of people are taking hospital only cover as compared with before and what percentage are buying front-end deductible products compared with before?

So you will be able to give me some information as to comparison over time of those products (front-end deductible, hospital only and exclusionary covers)?

Answer:

Quarter	Proportion of Persons Covered by Hospital Insurance with Front-end Deductible	Hospital Only Persons as a Proportion of Total Hospital	Proportion of Hospital Members with Exclusionary Cover
Dec-98	38%	25%	6%
Mar-99	38%	24%	6%
Jun-99	38%	24%	6%
Sept-99	39%	23%	6%
Dec-99	40%	23%	6%
Mar-00	41%	23%	7%
Jun-00	50%	24%	5%
Sept-00	52%	24%	5%
Dec-00	53%	24%	4%

Source: Private Health Insurance Administration Council

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000200

Topic: GAP COVER ADVERTISING

Written Question on Notice

Senator Evans asked:

(a) What is the timing of this campaign?

(b) What media will it involve?

(c) What is the link between the funding of programs for the implementation of simplified billing systems and the placement of advertisements for new gap free products?

(d) Who instigated this advertising campaign and where is the evidence that such a campaign is needed?

(e) Did the Department try to get the private health industry to fund this campaign from their own resources given that it is essentially a matter between the funds and their consumers?

Answer:

(a) The campaign is still in the developmental phase and there are no firm dates.

(b) The campaign is still in the developmental phase therefore the mix of media forms that will be used as part of the campaign are yet to be decided.

(c) The Simplified Billing Budget measure aimed to promote the widespread take-up of simplified billing. This measure was proposed to achieve a greater degree of simplified billing, facilitated by enhancing the role of billing agents and complemented by providing funding and incentives to encourage the conduct of simplified billing procedures electronically. However trends have shown an increasing proportion of simplified billing is occurring directly via no or known gap arrangements. Therefore efforts to increase simplified billing will be more effective if targeted at increasing the awareness and utilisation of no or known gap cover. A communication strategy, of which advertising is a component, to promote the existence and availability of gap cover arrangements will also result in the widespread take-up of simplified billing.

(d) Legislation was passed in August 2000 which enabled health funds to offer gap cover without the need for contracts. The need for a campaign was determined by Government on the basis that the Government has a responsibility to inform the community of these recent changes.

(e) No. As the campaign resulted from changes to Government legislation, it is necessary for the Government to run a communication campaign to ensure consumers are provided with unbiased information which is not exclusively driven by competitive commercial interests.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000256

Topic: ACCC FEDERAL COURT ACTION

Written Question on Notice

Senator Evans asked:

Given that two health funds currently face charges for misleading advertising from the ACCC, did the Department consider forcing the industry to fund corrective advertisements to clear up the confusion amongst consumers about waiting periods, gap free products and the pre-existing rule?

Answer:

No. It is the role of the ACCC and not the Department of Health and Aged Care, to monitor health fund advertising and to take action where necessary

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH ..... Question: E01000201

Topic: CONSUMER ISSUES

Written Question on Notice

Senator Evans asked:

(a) What are the reasons for the long delay in producing the 'key features statements' and simplified products that the consumer can understand?

(b) What is the progress on reaching agreement on the adoption of common rules on the transfer of entitlements between funds?

(c) What is the progress on reaching agreement on the scope of exclusions and what procedures is it agreed are appropriate to be excluded from health insurance products?

(d) What is the progress on defining limits for front end deductible products?

Answer:

(a) The delay in producing the Key Features Statement is due to the resource demands placed on all involved, including the Department, the industry and other stakeholders, in the development of the Key Features Statement.

The second stage of the Key Features Statement project, which involves finalisation of the text and development of guidelines for its use, is well underway.

The Key Features Statement will be used by new as well as existing members to select or transfer to a private health insurance product which best meets their needs and to gain a clearer understanding of their product benefits and entitlements.

With regard to simplified private health insurance products, individual health funds are responsible for product design.

(b) Common rules for the transfer of entitlements between funds have been endorsed by the Department and communicated to the industry via Health Benefits Circular number HBF 688 PH 428 on 30 January 2001. These common rules were developed by the Private Health Insurance Ombudsman in consultation with the Department and health funds.

(c) The Department is undertaking preparatory work for a roundtable discussion with key stakeholders to look at the suitability of products that restrict benefits, including products with exclusions and front-end deductibles.

(d) See answer to (c) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000203

Topic: MEDICARE LEVY SURCHARGE EXEMPTIONS

Written Question on Notice

Senator Evans asked:

What is the correct position about which forms of health insurance provide an exemption from the Medicare Levy Surcharge?

Answer:

For single people, hospital insurance with a front-end deductible of $500 or less will provide an exemption from the Medicare Levy Surcharge.

For couples and families, hospital insurance with a front-end deductible of $1000 or less will provide an exemption from the Medicare Levy Surcharge.

People who had already purchased a hospital insurance product with a front-end deductible greater than $500 for singles or $1,000 for families/couples, on or before 24 May 2000 are exempt from the Surcharge while ever they maintain continuous membership to the same hospital table.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000257

Topic: PUBLIC HOSPITAL – PRIVATE INSURANCE

Written Question on Notice

Senator Evans asked:

(a) Is a person holding a private insurance product offering insurance for 'public hospital only' coverage exempted from the payment of the medicare Levy Surcharge?

(b) If not, why, given that a private patient in a public hospital is relieving the Commonwealth in the same way that a private patient in a private hospital is?

Answer:

(a) Yes

(b) Not applicable

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH .....Question: E01000204

Topic: MEDICARE LEVY SURCHARGE ENFORCEMENT - COMPLAINTS

Written Question on Notice

Senator Evans asked:

(a) Has the Department received complaints from people affected by the July 2000 cut off for health insurance products with an excess greater than $500 gaining exemption from the Medicare Levy Surcharge?

(b) Is this change well understood in the Health Insurance industry and the accountancy profession?

Answer:

(a) Since 1 July 2000, the Private Health Insurance Information Line has received 833 calls regarding the Medicare Levy Surcharge. The majority of these callers were seeking more information regarding the Surcharge. It is not possible to say how many of these calls were complaints.

(b) The Department issued comprehensive advice (Health Benefits Circular number HBF 636) to health funds on 25 May 2000 detailing the changes to the Medicare Levy Surcharge. This Circular also provided health funds with a set of questions and answers to assist them to answers queries from consumers. Since this time there has been no significant indication from the industry during its regular consultations with the Department that further clarification is required.

The Department can not comment on whether this change is well understood by the accountancy profession.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E01000205**

Topic: MEDICARE LEVY SURCHARGE ENFORCEMENT – PUBLICISED DETAILS

Written Question on Notice

Senator Evans asked:

Where has the Department publicised the details of the eligibility criteria for gaining the exemption from the Medicare Levy Surcharge?

Answer:

The Department of Health and Aged Care has policy responsibility for the type of hospital insurance product that people need to take out in order to be exempt from the Medicare Levy Surcharge.

The Australia Taxation Office has responsibility for all other eligibility criteria for gaining an exemption from the Medicare Levy Surcharge.

The Minister for Health and Aged Care issued a press release on 24 May 2000 announcing the change to the front-end deductible hospital product that people would need to take out in order to be exempt from the Medicare Levy Surcharge.

Information was also placed on the Department of Health and Aged Care's website and provided to the Commonwealth Private Health Insurance Information Line to answer queries from consumers.

The Department also issued Health Benefits Circular number HBF 636 to health funds on 25 May 2000 detailing the changes to the eligibility requirements for exemption from the Medicare Levy Surcharge. This Circular also requested health funds ensure that all members were aware of the changes and provided health funds with a set of questions and answers to assist them to answers queries from consumers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000165**

Topic: BIO21 – GRANTS PROVIDED TO MONASH AND MELBOURNE UNIVERSITY

Hansard Page: CA 17

Senator Evans asked:

How much did each university get?

Answer:

Monash University $5.5m and Melbourne University $9.5m.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000170**

Topic: TEMPORARY RESIDENT DOCTORS

Hansard Page: CA 84

Senator West asked:

How many of the 79 have sought exemptions or release from the contract because of some particular problem?

Answer:

The Commonwealth has not been notified of any withdrawals from the State Schemes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000171**

Topic: TASMANIAN HEALTH CARE REPORT

Hansard Page: CA 84

Senator Denman asked:

There has been a report into health care on the west coast of Tasmania, a general report. I think it is by the state government. That is one of the points of the report.

Answer:

We believe that the report to which the Senator was referring is entitled "Health Needs Assessment of the Communities of Rosebery, Zeehan and Tullah". This was commissioned by the Tasmanian Department of Health and Human Services, and prepared by Alberton Consulting in partnership with Di Hollister. The report is dated 10 November 2000. It looked into a number of health issues in these communities, including the viability of the Rosebery Hospital. It incorporated significant community consultation and proposed a number of recommendations.

While none of the recommendations deal with the issue of consistency of medical care, the matter is raised on page 27:
"Community members view doctors as the anchor of health services and many interviewed expressed concern about the difficulties experienced in recruiting and retaining doctors in the Rosebery and Zeehan practices."

We believe that the Tasmanian 5 Year Overseas Trained Doctor Program could provide the opportunity to address these sorts of issues in rural and remote communities of Tasmania. Under the program, an appropriately trained doctor commits for five years general practice work in an approved location. It is expected that the Commonwealth would have no problem with such doctors being placed in Rosebery or Zeehan.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001
OUTCOME 9: HEALTH INVESTMENT **Question: E01000123**

Topic: CLINICAL SCHOOLS

Hansard Page: CA 102

Senator West asked:

(a) Have you at some state provided us with the criteria and the guidelines you used to assess them? (Mr Wells undertook to provide them again)

(b) Since the Rural Stocktake was completed, has Dr Best received any payments from the department for work carried out? What contact did Dr Best have with the assessment panel, officer of the Department, the Minister's office or the Minister himself?

(c) Did any of the proponents not submit a valid proposal by the due date?

(d) I am trying to get in my mind some comparison of the numbers of teaching undergraduates that you would expect at a clinical school and what you would expect the size of the departments of rural health to be, or even what has been put in the proposals.

(e) We do not know how much that particular one (Lismore) is going to receive for four years?

Answer:

(a) As previously provided, attached is a copy of the letter sent to the Deans of Australian medical schools inviting expressions of interest for the establishment of rural clinical schools and University Departments of Rural Health. Attached to this are the objectives and criteria for the establishment of these facilities.

(b) Since the completion of the Rural Stocktake, Dr Best carried out a workshop with University Departments of Rural Health on population health strategies and approaches, and provided advice on the rural chronic disease initiative. Dr Best received payment of a total amount of $9300.70 (GST exclusive) for this work.

Additionally, Dr Best sits on a number of Departmental research, education and training committees and may be reimbursed for some of this activity equitably with other committee/panel representatives. These commitments require some contact with the Department as necessary. Dr Best also has an appointment as Chairman of the Strategic Research and Development Committee of the National Health and Medical Research Council for the 2000-2003 Triennium. He has received $28,650.34 remuneration to date this financial year in accordance with the relevant determinations of the Remuneration Tribunal.

There was no formal constituted assessment panel as relevant departmental staff within the Health Industry Investment Division (HIID) and the Office of Rural Health (ORH) worked on the project as part of their line responsibilities. Dr Best initiated discussions with staff from time to time as did other people interested in the rural initiatives. This is normal in a consultative process and staff are expected to listen to a range of views. At the beginning of the process when inviting universities to make expressions of interest, the Department made it clear that it would deal only with the universities and not through intermediates. While a range of views were put to the Department from people who were not part of the assessment process, at no time did the Department's deliberations involve outside parties. Specifically Dr Best was not included in the Department's deliberative process.

(c) The Department received all submissions for the development of rural clinical schools and University Departments of Rural Health within an agreed timeframe.

(d) It is expected that rural clinical schools will enable at least 25 per cent of medical students to receive a minimum of 50 per cent of their clinical training in rural areas.

Presently the Department is negotiating details surrounding exact numbers of medical students to meet this objective with respective medical schools.

Contracts with the various University Departments of Rural Health do not specify actual student numbers nor the anticipated duration a student spends with each placement. Student placements are only one of a range of activities undertaken by University Departments of Rural Health.

(e) Negotiations on funding are yet to be completed between the Department and the universities for the two new University Departments of Rural Health (UDRH). The maximum amount of recurrent funding provided to the existing individual Departments of Rural Health ranges from $1 million to $1.5 million per annum.

Question: E01000123
ATTACHMENT A

Dear

I am writing to follow up on our discussions on 7 July 2000 regarding the Government's commitment to establish nine new clinical schools and three additional University Departments of Rural Health (UDRH) across Australia.

The Government's overarching objective for the implementation of these initiatives is to develop a rural focused national network of health professional education and training which is based upon a strategic and collaborative framework.

As raised at our meeting, the mechanism by which these new initiatives will be established is not prescriptive. The broad spectrum of education and training for health professionals has the potential to support a variety of models which facilitate the delivery of education and training in rural areas. Predominantly these have been identified as clinical schools and UDRH, as well as alternative rural health school models seeking to combine the key features of both a clinical school and a UDRH. It is acknowledged that a range of variables will impact on the development and focus of these initiatives, including geographic location, population base, existing infrastructure, and current educational arrangements.

To this end, I would therefore like to invite your medical school to submit an expression of interest regarding the establishment and operation of a clinical school, a UDRH, or alternative rural education and training model, which clearly addresses the attached criteria and objectives. The Department is happy to liaise and provide assistance as necessary to facilitate the development of proposals. If you have any questions, in the first instance please contact Cathy Wall regarding clinical schools (02 6289 5636) or Craig Lindsay regarding UDRH (02 6289 3717).

Expressions of interest are expected to be short, concise submissions, which include an indicative budget. The key features of proposals should be outlined, indicating as to how they will contribute to the Government's Policy Objectives (as follows).

It is also important that your expression of interest demonstrates support from the relevant State or Territory health department, because of the impact that new educational facilities have on local area health services.

It should be noted that more detailed proposals may be sought during contract negotiation. I look forward to working with you to establish and implement these new and innovative long-term initiatives for the provision of medical education and training across Australia.

Yours sincerely

Mr Robert Wells
First Assistant Secretary
Health Industry and Investment Division
July 2000

Question: E01000123
ATTACHMENT B

ESTABLISHMENT OF NEW CLINICAL SCHOOLS, UNIVERSITY DEPARTMENTS OF RURAL HEALTH AND RURAL HEALTH SCHOOLS IN AUSTRALIA

The Federal Budget 2000-2001 provides $562 million for the implementation of a Regional Health Strategy to increase the availability and viability of health services in rural and regional Australia.

One component of the Strategy is the establishment of nine new regional clinical schools and three additional University Departments of Rural Health (UDRH), at a cost of $117.6 million over 4 years. These initiatives will strengthen the rural focus in training for health professionals and increase the number of health professionals in rural and regional areas where the clinical schools and UDRH are located.

Detailed below are the key policy objectives and core criteria seen as imperative to developing and establishing a strong and sustainable national rural education and training network.

Policy Objectives

The Government aims to develop a rural focused national network of medical education and training which:

- Encourages rural students to study medicine and other health professions.
- Enables medical schools to strengthen their presence in rural areas and maximises health professional student training in rural settings.
- Provides strategically located educational facilities in every State and Territory.
- Is based on collaborative models of education.
- Both supports and is supported by rural communities.
- Fosters community development.

Education Models

It is recognised that there is a need for a diversity of models that reflect and accommodate existing educational arrangements and demographic factors such as population distribution.

It is anticipated that the establishment of a strong national education and training network for health professionals will be based upon the following 3 educational models:

Clinical Schools

It is expected that proposals for the establishment of clinical schools should address the following criteria:

- Enable 25% of medical students to undertake a significant part of clinical training in rural Australia.
- Build on existing local and regional infrastructure, including University Departments of Rural Health, regional universities etc.
- Have the capacity to attract and support both specialist and GP teaching staff with clinical loads.
- Demonstrate support from the local medical profession and the local rural community.
- Develop and maintain links with local and regional community at all levels, outlining mechanisms for involving community involvement in all stages of development.

University Departments of Rural Health

Proposals to establish University Departments of Rural Health (UDRH) should demonstrate:

- Ability to establish strategic links and partnerships necessary to establish a multi-disciplinary centre located in a rural or remote setting, which provides academic training and professional development for health care workers.
- Capacity to forge links with academic institutions and other rural/remote health education and training bodies, including clinical schools.
- Capacity to equip a range of health professionals with practical skills in preventive medicine applicable to remote settings.
- Strategies to engender an environment in which health professionals become more culturally aware and sensitive to Indigenous health issues.
- Expertise in preventive and population medicine which will act as a resource for all health professionals working in the area.
- Capacity to develop innovative service delivery models to meet the needs of the identified area.

Rural Health School Models

This model comprises key features of both a clinical school and a UDRH and is likely to be distributed upon a geographical basis. There may be considerable variation in models which are proposed as Rural Health Schools, ranging from a UDRH with some features of clinical school to a clinical school with some features of a UDRH.

Medical schools may wish to expand and develop the role of existing UDRH to encompass clinical school functions to become a Rural Health School. It is acknowledged that some areas of Australia may not have a sufficient population base in discreet areas to support a clinical school as described above. In these areas, it may be most practical to establish a Rural Health School.

Expressions of interest for Rural Health Schools should address criteria from both the clinical school and the UDRH criteria with a clear description of how the functions will complement each other.

Submissions

All expressions of interest, irrespective of their focus, should include:

- A clearly defined set of objectives, outcomes and performance indicators
- A draft workplan.
- Budget estimates.
- Documentation of support from the relevant State or Territory health department.
- Where appropriate, demonstrate collaboration between medical schools, as well as with rural communities, including formal consultation and management mechanisms.
- A draft evaluation strategy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000124**

Topic: BONDED SCHOLARSHIPS

Hansard Page: CA 107

Senator West asked:

(a) You do not know how many applications have been received for the scholarships at this stage? I am interested to know how many offers have gone out given that the academic year is now starting and the students?

(b) Mr Wells undertook to provide the number of scholarship places at each medical school.

Answer:

(a) The Medical Rural Bonded (MRB) Scholarship scheme provides for 100 new medical school places each year for Australian medical students beginning in 2001.

As at 8 March 2001 the Commonwealth has received 99 acceptances for the MRB scholarships and has been advised by the relevant university to expect the written acceptance for the outstanding scholarship shortly.

Each of the participating universities was responsible for the receipt of applications, recruitment process, and the awarding of their allocation of scholarships under the MRB Scholarship Scheme.

The Department does not currently have figures of offers made or the numbers of applications received. However, it is intended that part of the review of the MRB Scholarship Scheme by the Commonwealth will include gathering estimates of the number of offers and applications received by each university participating in this Scheme. This review will be undertaken in March/April 2001 after data from the universities March census report are available.

(b) The number of scholarship places allocated to each medical school is:

University	Places 2001 (actual as at 1/3/01)
University of Sydney/ACT	15
Newcastle University	10
University of Tasmania	12
University of Adelaide	5
Flinders University of South Australia	10
University of NSW	5
University of Melbourne	10
Monash University*	0
University of Queensland	10
University of Western Australia	7
James Cook University	16
TOTAL	100

* Monash University is not open to first year students (including Bonded Scholars) in 2001 as it is undergoing administrative changes to become a five year course. It will be included in the distribution of places for 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000166**

Topic: SPECIAL EXPERT COMMITTEE ON TRANSMISSIBLE SPONGIFORM ENCEPHALOPATHIES

Hansard Page: CA 39 to 41

Senator Forshaw asked:

(a) What is Professor Thomas representative role, if I can term it that, on the Council itself?

(b) Is she on the expert committee representing consumer interests?

(c) Was there any consideration given to appointing somebody from outside the council to represent the consumer interests?

(d) Following the Committee's initial meeting there was a press release issued. Check meeting date and date press release was issued.

(e) What type of risk assessment analysis will the committee be undertaking?

Answer:

(a) Professor Thomas was appointed to the Council in her capacity as being a person with knowledge of the needs of users of social welfare services.

(b) Yes.

(c) A number of candidates were considered by the Council, however there was a short timeframe available to identify and appoint persons to the Expert Committee. The Council appointed Professor Thomas due to her immediate availability, her keen interest in consumer issues and in the work of the Council (having been instrumental in bringing a consumer focus to the work of Council and its Committees).

(d) The Expert Committee first met on Tuesday, 30 January. A Press Release was issued on Friday, 2 February.

(e) Priority questions for consideration by the Committee, as agreed at the meeting of 30 January 2001, are at Attachment A.

Question: E01000166
Attachment A

NHMRC Special Expert Committee on

Transmissible Spongiform Encephalopathies

PRIORITY QUESTIONS FOR CONSIDERATION BY THE COMMITTEE

Epidemiology of BSE
- Current situation in UK
- Current situation in other countries
- Adequacy of surveillance
- Effects of slaughter under 30 month rule
- Situation in older animals
- Utility of screening tests for asymptomatic BSE

Assessment of risk of BSE spreading to other countries through
- Developing countries importing British meat meal up to 1996
- Cattle vaccines prepared with bovine serum
- Live cattle transport or other means (eg semen, embryos)

Assessment of risk of BSE spreading through sheep or other means

Epidemiology of Variant CJD
- Emerging situation in UK
- Other countries
- Adequacy of surveillance
- Utility of screening tests

Adequacy of evidence linking vCJD to consumption of BSE-infected tissue

Assessments of vCJD and CJD risk
- Size of epidemic in UK and other countries
- Size of immigrant and visitor epidemic in Australia
- Magnitude of risk with blood donations in Australia
- Magnitude of risk of vCJD or classical CJD spreading through
- Breaches of infection control guidelines
- Organ or tissue donation or transplantation or xenotransplantation
- Size of any epidemic due to imported beef foodstuffs
- UK, Europe or developing countries
- Magnitude of risk from human vaccines exposed to bovine materials
- Magnitude of risk from other therapeutic products
- Magnitude of risk from deer velvet and any other alternative therapies
- Magnitude of risk from processing of human blood products of overseas origins

Comment on emerging technologies that may inform risk assessment and risk management

Comment on the control measures and policies already introduced by government

Provide advice about surveillance and research, and about action to minimise all identified or potential risks to the Australian population.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000167**

Topic: TERMINATION OF PREGNANCY

Hansard Page: CA 109

Senator Harradine asked:

Revised answer to question provided in E017 on the draft report relating to Termination of Pregnancy. Answer provided in November 2000.

Is the NHMRC or any of its Committees doing any other work relating to abortion at the present time? If so please provide details.

Answer:

The NHMRC is currently preparing information pamphlets for general practitioners and women outlining the methods of and risks associated with termination of pregnancy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME: 9 HEALTH INVESTMENT **Question: E01000168**

Topic: TERMINATION OF PREGNANCY – WORKING PARTY MEETING

Hansard Page: CA 109-111

Senator Harradine asked:

Termination of Pregnancy Working Party meeting held on Friday, 10 November 2000

(a) Provide the Committee with a copy of the minutes for this meeting.

(b) Was there a meeting held in February 2000?

(c) Was Dr Edith Weisberg a member of the original committee, and why is she on it?

(d) Provide a short CV and area of expertise of the various members of the Working Party.

(e) Where is the person or persons that have a very intimate knowledge of post-abortion trauma and who have been involved in counselling persons with post-abortion trauma?

Answer:

(a) A copy of the minutes of the meeting of the NHMRC Termination of Pregnancy Working Party on Friday 10 November 2000 is attached (Attachment A)

(b) No, but there was a meeting held on 8 February 2001.

(c) Dr Weisberg was a corresponding member of the NHMRC Working Party that developed the 1997 Information Paper on Termination of Pregnancy. As a corresponding member Dr Weisberg was asked to provide written comments on the draft report. She did not attend meetings of the Working Party.

Dr Weisberg is a member of the NHMRC Working Party on Termination of Pregnancy that was appointed in November 2000. Dr Weisberg was chosen by the NHMRC Health Advisory Committee as an individual with specialist knowledge of the field of sexual health and because she is a practising sexual health practitioner.

(d) Please refer to page 2 of the minutes of the meeting held on 10 November 2000 (Attachment A)..

(e) Dr Robert Grenfell, Dr Edith Weisberg and Dr Christine Bayly are experienced clinicians on the Working Party. They each have broad and considerable experience in women's health, including significant experience in the counselling and management of pregnant women, women considering termination of pregnancy, women having a termination and women who have had a termination in the recent and distant past.

Question: E01000168
Attachment A

NHMRC Termination of Pregnancy Working Party

WORKING PARTY MEETING

10.35am – 3.40pm

Friday 10 November 2000
Meeting Room #1, Golden Wing Lounge, Tullamarine Airport
MELBOURNE

MINUTES

Participants:

Dr Rosemary Aldrich (Co-Chair)
Dr Robert Grenfell (Co-Chair)
Dr Christine Bayly
Ms Michele Kosky (11.45am - 1.10pm by teleconference)
Dr Julia Shelley
Dr Edith Weisberg

Office of NHMRC:

Mr David Adcock
Mr Nicholas Duell (Secretary)

1. OPENING OF MEETING AND WORKING PARTY MEMBER INTRODUCTIONS

Opening remarks:

- Dr Grenfell made reference to the information paper prepared but not endorsed by NHMRC that was published in May1997 but subsequently withdrawn in early 1998 after the factual accuracy of the document was challenged.
- While the document is quite comprehensive it was not obviously targeted to a specific audience.
- It was noted that the NHMRC Working Party on Termination of Pregnancy has received a very clear brief from Council via the Health Advisory Committee.
- The brief is for the development of information pamphlets for general practitioners and women outlining the methods of and risks associated with termination of pregnancy.
- Dr Grenfell noted that all Working Party discussions would be regarded as being in confidence.
- Any media enquiries received by Working Party members should be referred to Mr Brett Heffernan, the NHMRC Media Liaison Officer.
- All media statements will be made through Dr Aldrich following clearance by the NHMRC Media Liaison Officer.
- Working Party members may however indicate that it is the intention of the NHMRC Working Party to prepare two brief pamphlets, one for general practitioners and one for women presenting evidence-based information on the methods and risks of termination of pregnancy.

Working Party Member Introductions:

- **Dr Robert Grenfell** is a general practitioner from rural Victoria with a diploma in obstetrics.
- Dr Grenfell is co-Chair of the Working Party and is also a member of NHMRC Health Advisory Committee.
- Dr Grenfell noted the importance of pre- and post-counselling. Dr Grenfell noted that he sees morbidity as a result of the deficiencies in this area. These deficiencies are particularly evident in the rural service environment.
- **Dr Rosemary Aldrich** is a public health physician, the Executive Officer of the Newcastle Institute of Public Health and a conjoint lecturer at the School of Population Health Sciences, Faculty of Medicine and Health Sciences, University of Newcastle.
- Dr Aldrich is co-Chair of the Working Party and is also a member of NHMRC Health Advisory Committee.
- As a qualified journalist Dr Aldrich brings particular expertise in the areas of communications strategies and the appropriate framing and structure of information documents.
- **Dr Christine Bayly** is a practising gynaecologist at the Royal Women's Hospital Melbourne (RWH) and has a Masters Degree in Public Health. Dr Bayly's role as Divisional Director of Community Health Services at RWH includes management responsibility for the provision of abortion and related services.
- Dr Bayly is the Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) representative on the NHMRC Working Party and is also the Chair of the RANZCOG Working Party on Termination of Pregnancy.
- Dr Bayly noted that the RANZCOG Working Party is likely to be concerned with producing statements on drugs, methods and training associated with termination of pregnancy.
- Dr Bayly has worked extensively in the clinical area of infertility.
- **Dr Julia Shelley** is an epidemiologist at the Centre for Study of Mothers' and Children's Health, La Trobe University.
- Dr Shelley is currently undertaking research that is highly relevant to the NHMRC Working Party.
- Dr Shelley's research includes randomised controlled trials on women who have miscarried in the first trimester of pregnancy and issues surrounding complications of termination of pregnancy and methods used.
- **Dr Edith Weisberg** is a practising sexual health physician and is Director of Research, FPA Health.
- Dr Weisberg is a senior clinical lecturer in the Department of Obstetrics and Gynaecology working with Professor Ian Fraser at Sydney University.
- Dr Weisberg was a corresponding member of the NHMRC Working Party that developed the 1997 Information Paper.
- Dr Weisberg was involved in a 1992 project that analysed termination statistics in NSW. Dr Weisberg has also undertaken a study on misoprostol.
- **Ms Michele Kosky** is the Executive Director of the Health Consumers Council of Western Australia.
- Ms Kosky is the NHMRC consumer representative and has been involved in the development of many consumer documents on behalf of the NHMRC.

Discussion:

- Dr Bayly indicated that in her capacity as practising gynaecologist in the Community Health Services Division at the Royal Women's Hospital Melbourne she has drafted a response to the newspaper article on abortion and the prostaglandin drug misoprostol that appeared in the Sunday Age on 5 November 2000.
- Dr Aldrich acknowledged that members are experts in their field and are free to put their professional position in the public domain not as Working Party members but as health and medical professionals in their own right.
- Members acknowledged that they are bringing their expertise to the Working Party not a specific ideological position.

2. HISTORY OF NHMRC TERMINATION OF PREGNANCY PROJECT

Discussion:

- Members discussed the status of the revised draft of the *Information Paper on Termination of Pregnancy in Australia*. It was noted that the Information Paper was released but not endorsed by NHMRC in 1997.
- It was noted that even though the Information Paper was formally withdrawn in 1998 it remains in the public domain and some people still use it as a reference document.
- The Working Party will refer to original sources rather than citing the Information Paper.
- The potential risks to the process for the development of information pamphlets for GPs and women were discussed and its was agreed that the Working Party must strictly observe the terms of reference.

3. NHMRC ENDORSED TERMS OF REFERENCE

Discussion:

- The NHMRC endorsed terms of reference were noted and accepted.
- The documents will be labelled as information pamphlets. They are not statements, guidelines or recommendations.
- Evidence based information pamphlets will be produced in order to provide information on the methods and risks associated with a particular procedure as for any other medical procedure.
- The information pamphlets will not discuss ethical positions.
- Analogies were drawn with other procedures including angiography. This procedure also varies in success, will vary depending on the practitioner and pre- and post-counselling is a crucial component.

4. AIMS, OBJECTIVES AND DISSEMINATION STRATEGY

General discussion:

- Information items included in the meeting agenda were discussed at length.
- The scare-mongering approach and the inaccuracy of the document: *Abortion Information and the Law – What every doctor needs to know*, Doctors' Legal Safeguards Group, 2nd edition, 2000 was noted. The authors of this document remain anonymous and the Working Party will not be acknowledging it.
- The format of the document: *Medical Risk of Induced Abortion and of Carrying a Pregnancy to Term – Information for General Practitioners*, WA Health 1998 was considered to be an appropriate model for the NHMRC pamphlets although the content will be different, less directive and more user friendly.

- *The Care of Women Requesting Induced Abortion*, RCOG United Kingdom, 2000 was acknowledged as very thorough, well researched and evidenced document but of a different scale and format to the documents the Working Party will produce. This document will be a significant source of information and references for the NHMRC pamphlets.
- The possibility of producing one general document rather than two was discussed. Ms Kosky indicated that she did not believe it would be a problem for Council if one document rather than two was produced. Working Party members did not make a decision on this issue at the meeting.
- It will be at the discretion of Council as to whether the document(s) are subject to public consultation after completion.
- A one-page summary should be included given that GPs do not have the time to read through a twenty-page document. The remainder of the pamphlet will serve as a concise reference for GPs when they need it.
- It should be clearly stated that there are while there are polemic views on the issue of termination of pregnancy the Working Party is not suggesting that any view is the right one.

Dissemination

Discussion:
- Dissemination issues were considered in order to make sure that the target audience is being addressed.
- The Working Party will make recommendations to Council on implementation.
- GPs, women's health clinics, hospitals, community health clinics, obstetricians and gynaecologists will be targeted with the assistance of state health offices and professional colleges and societies.
- Language and culture are key considerations. Recommendations for dissemination for people from culturally and linguistically diverse backgrounds could include rewording and restructuring the pamphlet for women but without changing factual content, translating versions of the printed documents and/ or providing translator services.
- Public consultation was discussed.
- Professor Trang Thomas, NHMRC member with a vast professional experience in the field of multicultural affairs will be invited to assist the working party at the appropriate time.
- The pamphlets, when complete, will be available on the NHMRC web site. There could also be electronic links to the pamphlets on the NHMRC web site from those of several other peak organisations such as FPA and RANZCOG in order to provide easy and logical access to the information.

Methods of Termination of Pregnancy

Discussion:
- The issue of mifepristone, and the history of the 1994 application for Australian registration was noted. Members also noted the changes made to legislation as a result of political interventions on the use of abortifacients in Australia as a result of the 1994 application for registration.

- Mifepristone (with prostaglandin) should be referred to in the pamphlet as one method for termination of pregnancy, noting that the product was not available in Australia at the time the information pamphlets were published.
- Members noted that misoprostol is used in Australia and also noted that there are reports of the use of the cytotoxic drug methotrexate in this country.
- Doubts were expressed as to whether or to what extent the surgical procedure dilatation and extraction is identified separately from dilatation and evacuation in Australia.

Issues of Care

Discussion:
- The issue of referral liability of the practitioner was discussed at length.
- There is a responsibility to ensure that the patient has sufficient information to understand the issue they are making a decision about, prior to making a decision or giving consent to a procedure.
- Consumer orientation and knowledge with regard to termination of pregnancy was considered. Members noted that there are vast differences in the knowledge levels and emotional development of patients, depending on age, education and many other factors.
- Reference to State and Territory legal frameworks on access to termination will be avoided.
- There will not be a direct statement on practitioner liability as it is beyond the terms of reference.
- Reference should be included to levels of care and the obligation for practitioners to describe and provide counselling and or information about termination of pregnancy, as they would for any other health or medical procedure.
- The pamphlet should include sources of further information for patients.
- The pamphlet should reaffirm that it is important for the patient to have a good and trusting relationship with their GP.
- The Working Party recognises that information for women might also include information for partners.
- Ms Kosky referred to the format of the Health Consumer's Council (WA) Consumer Brochure on cerebral palsy: Information for Prospective Parents as a possible model for the Working Party.

5. TIMELINES AND DEVELOPMENT OF WORKPLAN

Review of Literature published since the writing of the 1997 Information Paper and the Engagement of Technical Writer

Discussion:

- Members agreed on the need to undertake a review of the literature on methods and effects of termination of pregnancy that has been published since the writing of the 1997 Information Paper. It was acknowledged that the review would not be a time consuming exercise as the number of documents to review is quite small.
- Dr Shelley agreed to supervise a review through La Trobe University of the literature published since the writing of the 1997 Information Paper. ONHMRC will fund the review upon request.

- The Secretary suggested that it would be preferable to engage a technical writer with a scientific background given that the entire pamphlet development process would most likely be subject to very close scrutiny by government and external stakeholders.
- Members agreed that the Secretary should approach Dr Ann Westmore on the basis of her previous work in the development of specialist medical and health related documentation.
- Members agreed that the Secretary should approach Dr Angela Kirsner (technical writer on standing offer with ONHMRC) if Dr Westmore is not available to undertake the project.

Proposed Outline for the draft NHMRC Information Pamphlet for Practitioners and Women on Termination of Pregnancy

- For the first draft two short paragraphs should be included for each general principle and method for the termination of pregnancy. The two paragraphs should include a brief explanation of the issue or procedure, indicating when it is appropriate to use a particular method and outlining the risks associated in each case.
- Evidence citations should be included in the section outlining specific methods for the termination of pregnancy.
- It may be appropriate to include information on the description, gestational period appropriate and risks associated with termination of pregnancy in table form.

Format

1. Introduction
2. General principles after confirmation of intra-uterine pregnancy
   a) Blood testing/ Rhesus
   b) Evidence (or not) about possible long term sequelae
      - Psychological
      - Breast cancer
      - Future fertility
      - Pre-term delivery
   c) Use of ultra sound
   d) Anaesthetics and pain management
   e) Ectopic pregnancy
   f) Procedural Risks
      - Infection
      - Haemorrhage
      - Anaesthetic complications
      - Retained products of conception
      - Failed procedure/ complications of pregnancy
      - Surgical trauma
3. Evidence about specific methods for and risks associated with termination of pregnancy
   a) Medical
      - mifepristone (RU486) + prostaglandin (while stating unavailability in Australia at this time)
      - methotrexate + prostaglandin
      - prostaglandin
   b) Surgical (with or without medical)
      - Suction curettage
      - Dilatation and Evacuation (D&E)
      - Dilatation and Extraction (D&X)
4. Concluding remarks

ACTION ARISING

1. A review of the literature published since the writing of the 1997 Information Paper should be undertaken as a matter of urgency

   Action officer: Dr Shelley in consultation with Mr Duell

2. The technical writer Dr Ann Westmore should be approached as a matter of urgency in order to canvass her willingness and availability to undertake the project. Dr Angela Kirsner should be contacted if Dr Westmore is unavailable.

   Action officer: Mr Duell

3. The development of pamphlets for practitioners and women. The pamphlets should be presented to the 138th Session of NHMRC in March 2001. The following general information might be incorporated depending on target audience:
   - A one-page summary;
   - Information on methods and risks of termination of pregnancy;
   - Reference to mifepristone, indicating that the product was not available in Australia at the time the information pamphlet was published;
   - Minimum levels of care and the obligation on the practitioner to describe the procedure as they would for any other health or medical procedure;

The pamphlet should follow the format indicated as the Proposed Outline for the draft NHMRC Information Pamphlet for Practitioners and Women on Termination of Pregnancy (noted here under item 5).

Action officers: Working Party, Secretariat and Technical Writer

PROJECT TIMELINE

14/11/00	Circulate minutes of the 10 November 2000 TOP Working Party meeting.
20/11/00	Engage technical writer.
20/11/00	Research Assistant to Dr Shelley to review and critically appraise the 1998-1999 literature.
08/12/00	Literature review completed
15/12/00	Dot point structure of pamphlet for medical practitioners including new references and two paragraphs on each point listed in the outline to be circulated to Working Party for consideration.
21/12/00	12.00pm Working Party Teleconference including the technical writer to consider first draft.
22/12/00	Redrafting by technical writer.
24/01/01	Face to face meeting of the Working Party in Melbourne with technical writer to discuss the penultimate draft and the dissemination strategy.
25/01/01	Redrafting by technical writer.
21/02/01	12.00pm Working Party Teleconference including the technical writer to consider final draft and obtain Working Party sign off.
08/03/01	Presentation at the 138th Session of NHMRC

Meeting Concluded at 3.40pm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000169**

Topic: CLONING

Hansard Page: CA 112

Senator Harradine asked:

Would you provide the committee with a copy of the document that you presented to the States? (Several documents - briefing notes, went out mid November 2000 to all states and territories and a clarifying statement handed out on 15 December and 31 January 2001).

Answer:

The following documents are included in support of this question

1. Letter from Dr Clive Morris from the Office of the NHMRC to the Head of each State and Territory Health Authority letter dated 1 November 2000.

Appendix I	Background information
Appendix II	1998 AHEC report - *Scientific, Ethical and Regulatory Considerations Relevant to Cloning of Human Beings*
Appendix III	Commonwealth Department of Health and Aged Care Options paper - *Options for the Development of a Complementary National Framework for Assisted Reproductive Technology and a National Ban on Cloning of Human Beings*
Appendix IV	Options paper (Legal analysis) – *Assisted Reproductive Technology: a comparison of regulation in all Australian jurisdictions*
Appendix V	NHMRC *Ethical Guidelines on Assisted Reproductive Technologies (1996)*

2. Australian Health Ethics Committee – National Health and Medical Research Council: Position on Cloning and Related Technologies (15 December 2000)

Question: E01000169

Attachment 1

NH

GPO Box 9848, Canberra ACT 2601 Australia
http://www.nhmrc.health.gov.au International Fax: 61 2 6289 9197
ABN 83 605 426 759

MRC

National Health and Medical Research Council

Contact for this correspondence:
Name: Ben Battisson
E-mail: ben.battisson@health.gov.au
Telephone: (02) 6289 9149
Facsimile: (02) 6289 9198

Dear

Australian Health Ministers' request for development of a national ban on cloning of human beings

At the Australian Health Ministers Conference (AHMC) on 27 July 2000, Ministers agreed that there is a need to ban cloning of whole human beings and that this should be pursued by each State and Territory in a manner that complements the bans in other jurisdictions. The Health Ministers further decided that the NHMRC should facilitate this national approach. The background to this decision and some additional information is at Attachment A.

The NHMRC will facilitate a process that will lead to a shared understanding of the issues involved in achieving a national ban on cloning of whole human beings and result in a report to Health Ministers identifying options for a way forward. Implementation will then be the responsibility of individual States and Territories, subject to Health Ministers' approval.

The timetable for this work is:

Initial meeting	15 December 2000
Development of options paper	December 2000/January 2001
Circulate paper for comment	February 2001
Second meeting	March 2001
Finalise report	April 2001
Report to AHMC	May 2001

I am writing to invite you to send a representative to the meeting of 15 December 2000. Your representative should have the knowledge and authority to contribute to discussions relating to current legislative frameworks and policy positions in your jurisdiction, as well as providing input into, and sign off for, the options paper.

The meeting will be held on 15 December 2000 at the Casselden Place Conference Centre, Level 8, 2 Lonsdale Street, Melbourne, commencing at 10am and concluding at 4pm. Refreshments and lunch will be provided however your representative's travel costs will be the responsibility of your authority.

I would be grateful if you would advise Mr Ben Battisson on telephone (02) 6289 9149, facsimile (02) 6289 9198 or by email at ben.battisson@health.gov.au of the name and contact details of the representative from your jurisdiction by no later than 20 November 2000. The reading material at Attachment A will form the basis of discussions at the meeting.

A copy of this letter has also been sent to …….. who was the contact officer in your authority for recent AHMC initiatives in assisted reproductive technology.

Should you have any queries about the meeting please do not hesitate to contact Mr Battisson.

Yours sincerely

(Authorised for release)

Dr Clive Morris
A/g Assistant Secretary
Centre of Health Advice, Policy and Ethics
Office of NHMRC

1 November 2000

Question: E01000169

Attachment 1

ADDITIONAL INFORMATION

Appendix I	Background information
Appendix II	AHEC report - *Scientific, Ethical and Regulatory Considerations Relevant to Cloning of Human Beings*
Appendix III	Commonwealth Department of Health and Aged Care Options paper - *Options for the Development of a Complementary National Framework for Assisted Reproductive Technology and a National Ban on Cloning of Human Beings*
Appendix IV	Options paper (Legal analysis) – *Assisted Reproductive Technology: a comparison of regulation in all Australian jurisdictions*
Appendix V	NHMRC *Ethical Guidelines on Assisted Reproductive Technologies (1996)* - may be accessed at http://www.health.gov.au/hfs/nhmrc/publicat/pdf/e28.pdf

[Note: Appendix II, III, IV have not been included in the electronic/printed volume]

Australian Health Ethics Committee

National Health and Medical Research Council:
Position on Cloning and Related Technologies
15 December 2000

1 Clarification

The NHRMC's position on the use of cloning and stem cell technologies was inadvertently mis-stated in Appendix 1 (Background Information) of the invitation from the NHMRC to the Head of each State and Territory Health Authority, dated 1 November 2000, to the 15 December 2000 meeting to be held in Melbourne. That appendix incorrectly stated that, in its report entitled *Scientific, Ethical and Regulatory Considerations Relevant to Cloning of Human Beings (1998)* (Cloning Report), AHEC had identified a number of key issues which included the need to draw a basic distinction between the cloning of *whole* human beings and therapeutic cloning. In fact, in the Cloning Report AHEC specifically rejected the distinction between so-called 'therapeutic' and so-called 'reproductive' cloning.

At 3.3 of the Cloning Report, AHEC pointed out that, although the objective for the sake of which cloning is conducted is ethically-significant, other things (including whether or not cloning technologies would involve destructive research on human embryos) are also ethically-significant. At 3.22 – 3.27 these points are elaborated. AHEC's Cloning Paper restated its position on experimentation on human embryos as set out in the NHMRC *Ethical Guidelines on Assisted Reproductive Technology (1996) (Ethical Guidelines)*. In so doing it rejected the position subsequently advanced by the Australian Academy of Science in its *Position Statement* of February 1999 (which employed the distinction between so-called therapeutic and so-called reproductive cloning).

2 Re-statement

The NHMRC policy on cloning and related technologies is summarized in the following extracts from the *Ethical Guidelines:*

Section 6 Research on embryos

6.1 Research on human embryos must take place within the limits prescribed by the law. In those States and Territories where there is no relevant legislation such research may only take place according to these Guidelines (see also Guideline 1.2).

6.2 Embryo experimentation should normally be limited to therapeutic procedures which leave the embryo, or embryos, with an expectation of implantation and development.

6.3 Non-therapeutic research which does not harm the embryo may be approved by an IEC.

6.4 Non-therapeutic research which involves the destruction of the embryo, or which may otherwise not leave it in an implantable condition, should only be approved by an IEC in exceptional circumstances. Approval requires:

- a likelihood of significant advance in knowledge or improvement in technologies for treatment as a result of the proposed research;
- that the research involves a restricted number of embryos; and
- the gamete providers, and their spouses or partners, to have consented to the specific form of research (see Guideline 3.2.5).

6.5 Protocols for ART in any clinic should take account of the success rates of fertilization typically achieved in that clinic and, on that basis, seek to avoid the likelihood of production of embryos in excess of the needs of the couple. Techniques and procedures which create embryos surplus to the needs of the infertility treatment should be discouraged.

Section 11 Prohibited/unacceptable practices:

11.1 Developing embryos for purposes other than for their use in an approved ART treatment program.

11.2 Culturing of an embryo in vitro for more than 14 days.

11.3 Experimentation with the intent to produce two or more genetically identical individuals, including development of human embryonal stem cell lines with the aim of producing a clone of individuals.

11.4 Using fetal games for fertilisation.

11.5 Mixing of human and animal gametes to produce hybrid embryos.

11.6 Mixing of gametes or embryos of different parental origin so as to confuse the biological parentage of the conceptus.

11.6 Placing an embryo in a body cavity other than in the human female reproductive tract.

11.8 Embryo flushing.

11.9 Commerical trading in gametes or embryos.

11.10 Paying donors of gametes or embryos beyond reasonable expenses.

11.11 The use in ART treatment programs of gametes or embryos harvested from cadavers.

3 Explanation

In Appendix 1 to the invitation from the NHMRC to State and Territory Health Authorities, the term "therapeutic cloning" was used mistakenly in summarising AHEC's policy.

The origin of this mis-statement follows: In the *Ethical Guidelines*, AHEC reaffirmed and applied the well-accepted distinction between (a) therapeutic research and (b) non-therapeutic research. Therapeutic interventions are interventions directed towards the wellbeing of the individual embryo involved and non-therapeutic interventions are interventions that are not directed towards the benefit of the individual embryo but rather towards improving scientific knowledge or technical application. Non-therapeutic experimentation includes both non-destructive procedures (which include observation) and destructive procedures.

The *Ethical Guidelines*, and in particular the section on research on embryos (section 6) and the list of prohibited/unacceptable practices (section 11), rely upon and apply this distinction between therapeutic and non-therapeutic research. The more-recently-coined term 'therapeutic cloning' collapses both (a) the distinction between therapeutic and non-therapeutic research on embryos and (b) the distinction between destructive and non-destructive experimentation on embryos. The creation of embryos specifically for research purposes, experimentation on those embryos and their subsequent destruction, etc. all fall under this term. It was because of the lack of transparency of the term 'therapeutic cloning', because the term concealed rather than revealed these ethically-significant differences, that AHEC rejected its use. AHEC said that, in the matter of cloning and related technologies, the fundamental distinction was between the production by cloning of whole human entities (such as human embryos) and the production by cloning of the component parts of those entities (such as cells, DNA, etc.). AHEC held that, whereas the latter has been an accepted part of medical and scientific research for over fifty years, the former should take place only in exceptional circumstances.

4 AHEC's current plan

The Commonwealth Minister for Health referred AHEC's Cloning Report to the House of Representatives Standing Committee on Legal and Constitutional Affairs. The Standing Committee is currently conducting its enquiry into the matters raised in the Cloning Report. At its meeting of 11th and 12th September, 2000, AHEC decided to await the report of this Committee before undertaking any further work on this subject.

However, a working party of AHEC is now undertaking, on behalf of the NHMRC, the necessary follow up of the enactment of the Gene Technology Bill 2000 and the 15 December meeting to develop a national ban on the cloning of human beings.

Dr Kerry Breen
Chairperson
Australian Health Ethics Committee

15 December 2000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000206**

Topic: POLLING AND "COMMUNITY CONSULTATION" PROGRAM

Written Question on Notice

Senator Evans asked:

What commitments have been made against the $4m "community consultation" initiative in the 2000-01 budget?

Answer:

Of the $4 million allocated over four years to consumer surveys of health system performance, $50,681.68 has been spent in the 2000-01 financial year. This sum (including GST) was paid to Albert Research for conducting research on consumer awareness and perceptions of medical practice corporatisation. At this stage no other funds have been committed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000209**

Topic: REPHASING OF MEDICAL RESEARCH

Written Question on Notice

Senator Evans asked:

(a) Why has there been such a large slippage in the medical research budget?

(b) The estimated actual spending shown in the May budget for Research grants in 1999/00 was $281m but the actual amount spent shown in MYEFO was just $186.1m? Why was there such a large difference given that the May Budget estimate was prepared just a few months before the end of the financial year?

(c) What is the explanation for the rest of the underspending – apart from the $32m, which is being rephased into 2000/01? Can you provide a full breakdown of spending on Administered Item No 1?

(d) How many grants were approved in 1999 and 2000 and what were the total amounts that these grants covered? How much of the 1999 funding was delayed because projects were unable to proceed?

(e) Has the real level of activity in the medical research sector actually increased given that there has been such a substantial underspend?

(f) The budget for 2000/01 is shown as $365m after the adjustment. Given we are now 8 months into this financial year, how much of these funds have been actually spent or committed? Will there be another large carry forward at the end of this year? What is the real pattern of increasing activity?

Answer:

(a) The National Health and Medical Research Council uses a calendar year rather than a financial year for the purpose of letting new grant rounds, in line with the academic calendar of administering institutions. By using the calendar year to control the business cycle, the true expense figures are distorted. Therefore the budget estimate for 1999/00 was overstated. When the estimate was derived it was very difficult to model accurately projected forward year expense and liability movement. The slippage is due to significantly lower expense than estimated and a significantly higher liability reduction than estimated. We have been aware of this problem with the forward estimates of expense and liability movement and the estimates have been corrected for this financial year.

Funding available for current year grants and prior year grant commitments was fully committed in 1999/00. $32.8m of grants committed but not expensed in 1999/00 were rephased to 2000/01 due to delays in processing and finalisation of these grants.

(b) The Department's transitionary process from cash based accounting to accrual based accounting during the 1999/00 financial year provided for *Outcome 9 Administered Item 1: Research Grants* to be over estimated on the basis of cash treatment being utilised, as against accrual treatment. The estimated actual that was provided in the 2000/01 PBS was based on the budget estimate for 1999/00.

The budget estimate for expense provided was overstated for the reasons in a) above. The Department incorrectly assumed the figure of $281m as the movement in liabilities for that year. The reduction in the liability was much higher than the estimate provided for. This resulted in a much lower expense compared to the budget estimate.

(c) Refer (a) and (b) above for the explanation

Breakdown of Administered Item 1 :

Strategic Research (tied)	$ 49k
Strategic Research (untied)	$ 114k
Health Research Support	$ 1,649k
Health Research RADGAC	$ 42k
Commissioned Research	$ 1,575k
Medical Research Development	$ 177k
Medical Research (New Grants)	$182,100k
Australian Medical Council	$ 375k
	$186,081k (Cash and Accrual)

The rephased amount of $32.3m was to provide for the accrued commitments due to the calendar business cycle of the Office.

(d) Grants let in 1999 = 642 grants representing $161m in expense.

Grants let in 2000 = 707 grants representing $182.8m in expense.

These figures are representational of the calendar years 1999 and 2000. A small percentage of the 1999 funding was delayed due to late acceptance of grants by recipients. All outstanding grants are taken up as commitment because the majority of outstanding grants are taken up at a later date.

(e) The increase in numbers of projects and funding for medical research shown in the figures in d) (above) and the fact that 682 new grants were let for the 2001 year (including new initiatives) with a total value of $230.3m (this figure is inclusive of the forward liability component of the new grants) show the increase in the level of research activity.

(f) The 2000/01 budget figure of $365m (liability) has been adjusted to $278.7m in projected expense for this financial year. Current expense projection provides assurances that this adjusted budget figure will be fully expensed/committed.

It is correct that there will be a large carry forward to cover liability. This is due to the Commonwealth's move to an accrual accounting environment as against a cash accounting environment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000207**

Topic: GST

Written Question on Notice

Senator Evans asked:

(a) How many new applications has the Department received from people seeking an exemption for goods or services from the GST on the grounds they are health products?

(b) How many complaints has the Department or the HIC received about the administration of the GST in the payment of grants?

(c) What issues have arisen about the implementation of the GST and the difficulties hospitals and other health organisations are having in correctly filling in the BAS statements?

(d) Does the Department maintain an ongoing monitoring activity in relation to the GST?

Answer:

(a) The Department provides input to general queries from members of the public, seeking information about GST policy and various health products. There is no formal mechanism for counting statements or requests for GST-free status by members of the public. However a search of Ministerial correspondence provides a figure of 17 letters where members of the public have suggested certain health goods or services should be GST-free, since 22 November.

Some 34 products or categories of products have been considered for recommendations about GST-free status following applications by businesses to either the Department or the Australian Taxation Office, since 22 November 2000.

(b) The Department holds no records of complaints made about the administration of the GST in the payment of grants. Calls and other communications received by the Department have been in the nature of general enquiries about the impact of tax reform on grant payments**.**

The Health Insurance Commission received three written complaints and many enquiries in respect to the administration of the GST (in relation to the payment of grants).The Health Insurance Commission was required to collect the Australian Business Numbers of health professionals to facilitate payments to them that would be subject to GST. Staff on telephone enquiries took a number of calls in relation to this requirement and related issues, however, the number of actual complaints was very small.

(c) Compliance by State and Territory institutions with taxation law requirements is the responsibility of State and Territory governments and hence the impact of BAS administration on public hospitals has not been monitored by the Commonwealth Department of Health and Aged Care.

An evaluation of Departmental co-funded Business Activity Statement workshops for Aboriginal and Torres Strait Islander organisations found that 71 per cent of organisations felt their organisations were prepared for the new tax system, with 92 per cent stating they understood the concepts of GST.

The Department does not become involved in the day to day administration of BAS in other health organisations and refers all queries to the Australian Taxation Office.

There are no ongoing or significant issues surrounding GST implementation. An issue that health organisations faced in the immediate period prior to tax reform was implemented was the uncertain nature of whether grants to and services rendered by organisations were subject to GST. However, this uncertainty has diminished as organisations become better informed.

(d) The Department does not maintain an ongoing monitoring activity in relation to the GST. The Department will undertake a yearly review of medical aids and appliances that are GST-free to take account of new technologies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000208**

Topic: GST ON PACEMAKER BATTERY LEADS

Written Question on Notice

Senator Evans asked:

Could the Department explain why GST is being applied to heart pacemaker leads? Here is a tax invoice provided by a recent heart patient who paid a 10 per cent GST on the two leads that go through his body from the pacemaker to his heart – total cost $254. As Mr Gilbert says in his letter "without the connection between my heart and my newly installed pacemaker I would be dead". Why aren't these leads GST exempt and will the Department act to have these products listed as GST exempt?

Answer:

The Australian Taxation Office has interpreted that pacemakers and their spare parts are GST-free. Pacemakers consist of an implantable pacemaker unit and the leads that connect it to the heart. Pacemaker leads are components of a pacemaker system and where supplied separately are regarded as spare parts for a pacemaker. Spare parts for pacemakers are GST-free. Pacemakers and spare parts are GST-free all the way down the supply chain.

If GST has been charged to a patient for the supply of pacemaker leads, this is incorrect. The patient may apply to the supplier of the leads for a refund of any GST paid. The supplier is then entitled to claim a credit for the GST on the next BAS lodged.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000217**

Topic: MEDICAL SCHOOLS – ASSESMENT OF PROPOSALS

Written Question on Notice

Senator Evans asked:

(a) What were the steps taken to assess the proposals and who was involved in that process?

(b) What steps were taken in relation to conflicts of interest and the declaration of pecuniary stakes by those involved in the assessment process?

Answer:

(a) The Department assessed proposals for the development of rural clinical schools and University Departments of Rural Health against stipulated criteria, which had been made publicly available in advance, simultaneously with consultations and negotiations involving universities, state/territory health authorities and community representatives.

This assessment process was an entirely internal process. The objectives and criteria are attached for your information (Attachments A and B).

(b) Throughout the assessment process which was undertaken by departmental staff, the Department adhered to its responsibilities and requirements concerning pecuniary stakes and conflict of interest issues. None of the departmental staff involved has a pecuniary or other conflict of interest.

The Department will remain cognisant of these requirements throughout the development of this initiative.

Question: E01000217
ATTACHMENT A

Dear

I am writing to follow up on our discussions on 7 July 2000 regarding the Government's commitment to establish nine new clinical schools and three additional University Departments of Rural Health (UDRH) across Australia.

The Government's overarching objective for the implementation of these initiatives is to develop a rural focused national network of health professional education and training which is based upon a strategic and collaborative framework.

As raised at our meeting, the mechanism by which these new initiatives will be established is not prescriptive. The broad spectrum of education and training for health professionals has the potential to support a variety of models which facilitate the delivery of education and training in rural areas. Predominantly these have been identified as clinical schools and UDRH, as well as alternative rural health school models seeking to combine the key features of both a clinical school and a UDRH. It is acknowledged that a range of variables will impact on the development and focus of these initiatives, including geographic location, population base, existing infrastructure, and current educational arrangements.

To this end, I would therefore like to invite your medical school to submit an expression of interest regarding the establishment and operation of a clinical school, a UDRH, or alternative rural education and training model, which clearly addresses the attached criteria and objectives. The Department is happy to liaise and provide assistance as necessary to facilitate the development of proposals. If you have any questions, in the first instance please contact Cathy Wall regarding clinical schools (02 6289 5636) or Craig Lindsay regarding UDRH (02 6289 3717).

Expressions of interest are expected to be short, concise submissions, which include an indicative budget. The key features of proposals should be outlined, indicating as to how they will contribute to the Government's Policy Objectives (as follows).

It is also important that your expression of interest demonstrates support from the relevant State or Territory health department, because of the impact that new educational facilities have on local area health services.

It should be noted that more detailed proposals may be sought during contract negotiation. I look forward to working with you to establish and implement these new and innovative long-term initiatives for the provision of medical education and training across Australia.

Yours sincerely

Mr Robert Wells
First Assistant Secretary
Health Industry and Investment Division
July 2000

Question: E01000217
ATTACHMENT B

ESTABLISHMENT OF NEW CLINICAL SCHOOLS, UNIVERSITY DEPARTMENTS OF RURAL HEALTH AND RURAL HEALTH SCHOOLS IN AUSTRALIA

The Federal Budget 2000-2001 provides $562 million for the implementation of a Regional Health Strategy to increase the availability and viability of health services in rural and regional Australia.

One component of the Strategy is the establishment of nine new regional clinical schools and three additional University Departments of Rural Health (UDRH), at a cost of $117.6 million over 4 years. These initiatives will strengthen the rural focus in training for health professionals and increase the number of health professionals in rural and regional areas where the clinical schools and UDRH are located.

Detailed below are the key policy objectives and core criteria seen as imperative to developing and establishing a strong and sustainable national rural education and training network.

Policy Objectives

The Government aims to develop a rural focused national network of medical education and training which:

- Encourages rural students to study medicine and other health professions.
- Enables medical schools to strengthen their presence in rural areas and maximises health professional student training in rural settings.
- Provides strategically located educational facilities in every State and Territory.
- Is based on collaborative models of education.
- Both supports and is supported by rural communities.
- Fosters community development.

Education Models

It is recognised that there is a need for a diversity of models that reflect and accommodate existing educational arrangements and demographic factors such as population distribution.

It is anticipated that the establishment of a strong national education and training network for health professionals will be based upon the following 3 educational models:

Clinical Schools

It is expected that proposals for the establishment of clinical schools should address the following criteria:

- Enable 25% of medical students to undertake a significant part of clinical training in rural Australia.
- Build on existing local and regional infrastructure, including University Departments of Rural Health, regional universities etc.
- Have the capacity to attract and support both specialist and GP teaching staff with clinical loads.
- Demonstrate support from the local medical profession and the local rural community.
- Develop and maintain links with local and regional community at all levels, outlining mechanisms for involving community involvement in all stages of development.

University Departments of Rural Health

Proposals to establish University Departments of Rural Health (UDRH) should demonstrate:

- Ability to establish strategic links and partnerships necessary to establish a multi-disciplinary centre located in a rural or remote setting, which provides academic training and professional development for health care workers.
- Capacity to forge links with academic institutions and other rural/remote health education and training bodies, including clinical schools.
- Capacity to equip a range of health professionals with practical skills in preventive medicine applicable to remote settings.
- Strategies to engender an environment in which health professionals become more culturally aware and sensitive to Indigenous health issues.
- Expertise in preventive and population medicine which will act as a resource for all health professionals working in the area.
- Capacity to develop innovative service delivery models to meet the needs of the identified area.

Rural Health School Models

This model comprises key features of both a clinical school and a UDRH and is likely to be distributed upon a geographical basis. There may be considerable variation in models which are proposed as Rural Health Schools, ranging from a UDRH with some features of clinical school to a clinical school with some features of a UDRH.

Medical schools may wish to expand and develop the role of existing UDRH to encompass clinical school functions to become a Rural Health School. It is acknowledged that some areas of Australia may not have a sufficient population base in discreet areas to support a clinical school as described above. In these areas, it may be most practical to establish a Rural Health School.

Expressions of interest for Rural Health Schools should address criteria from both the clinical school and the UDRH criteria with a clear description of how the functions will complement each other.

Submissions

All expressions of interest, irrespective of their focus, should include:

- A clearly defined set of objectives, outcomes and performance indicators
- A draft workplan.
- Budget estimates.
- Documentation of support from the relevant State or Territory health department.
- Where appropriate, demonstrate collaboration between medical schools, as well as with rural communities, including formal consultation and management mechanisms.
- A draft evaluation strategy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000218**

Topic: MEDICAL SCHOOLS – DR JACK BEST

Written Question on Notice

Senator Evans asked:

(a) In what ways was Dr Jack Best involved in the Rural Stocktake. Mr Wells says he 'did some work'. What work did he do and who else worked on the project. What proportion of the total effort was undertaken by Dr Best?

(b) Which University involved Dr Best directly in the meetings to discuss their proposal and what role did Dr Best play?

(c) What contact did Dr Best have with the assessment panel, officers of the Department, the Minister's office or the Minister himself?

(d) Has Dr Best received any payments from the Department for work carried out since completion of his Rural Stocktake?

Answer:

(a) The Contract for the Rural Stocktake was between the Department and Diagnosis Pty Ltd, of which Dr Best is a Principal. Dr Best held discussions with various key organisations in the delivery of rural health services, visited over fifty communities and held consultations with over two hundred rural professionals community leaders and citizens. Dr Best wrote the *Rural Health Stocktake*.

(b) Dr Best did attend one meeting held between the Department and the University of Sydney, at the request of the University of Sydney. The purpose of that meeting was for the University of Sydney to elaborate on its submission. Dr Best was present as an advisor to the University of Sydney.

Dr Best was not present at similar meetings regarding this initiative with the other universities.

(c) See E01000123 (b).

(d) See E01000123 (b).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000219**

Topic: MEDICAL SCHOOLS – COPY OF SUBMISSIONS

Written Question on Notice

Senator Evans asked:

(a) Can you supply a copy of the original University of Sydney and University of NSW submissions?

(b) What were the grounds given by the assessment panel for rejecting the proposal for a clinical school in Lismore in favour of one in Coffs Harbour? Can the comparative evaluation of the proposals be tabled?

(c) Why do you say that Sydney University 'in a sense' opted for the Coffs Harbour option?

(d) What was the original break up of NSW sought and what process was used to carve it up differently?

Answer:

(a) It is the Department's opinion that the proposals received from university medical schools are Commercial-In-Confidence documents. To this end, the Department will write to the Deans of the University of Sydney and the University of New South Wales to seek their approval to release their proposals to members of the Senate Community Affairs Legislation Committee.

(b) The University of New South Wales' submission proposes to build upon the current activity it has developed at Coffs Harbour and focuses on long term placements of medical students which typifies a rural clinical school facility rather than a University Department of Rural Health.

The University of Sydney proposed a 'Northern Rivers' UDRH which did not extend to Coffs Harbour. In discussions with NSW Health and the University of New South Wales (UNSW) it was clear that there was need and capacity for a rural clinical school for the Coffs Harbour/Port Macquarie areas.

(c) Sydney University had not proposed a Coffs Harbour development.

Attached for your information is an outline of the proposed locations for the new rural clinical schools and University Departments of Rural Health as recently announced by the Minister for the Department of Health and Aged Care, the Hon Dr Michael Wooldridge (Attachment A).

(d) The original 'coverage' as proposed by the universities was:

(i) Sydney University:
: Northern Rivers (Lismore, Tweed Heads, Grafton and surrounds including Moree and Walgett)
: 'Western Corridor' (Blue Mountains/Hawkesbury to central west including Dubbo, Orange and Broken Hill)
: Canberra and south eastern NSW
: Broken Hill (existing)

(ii) UNSW:
: Wagga/Greater Murray (existing)
: Midwestern NSW (Orange, Bathurst, Lithgow, Cowra, Parkes, Forbes), South coast (Nowra to Goulburn and Young), and
: Mid-north coast - Coffs Harbour

(iii) Newcastle:
: Kempsey; Armidale; Tamworth; Port Macquarie and Taree.

As can be seen in some instances the proposals overlapped in terms of geographic coverage and there were gaps. The Department made decisions based on the stipulated criteria to achieve optimum outcomes for medical students and the local communities and to ensure as broad a rural coverage as possible.

Question: E01000219
Attachment A

PROPOSED MODELS AND LOCATIONS FOR

NEW RURAL CLINICAL SCHOOLS AND

UNIVERSITY DEPARTMENTS OF RURAL HEALTH

Proposed New Rural Clinical Schools

Title	University	Location
1. Coffs Harbour Rural Clinical School	UNSW	New node of Wagga Wagga Rural Clinical School based at Coffs Harbour, extending to Port Macquarie and surrounds.
2. Dubbo Rural Clinical School	Sydney University	Mid-west NSW, based at Dubbo, extending to Broken Hill, Orange, and the surrounding districts.
3. Rockhampton/Toowoomba Rural Clinical School	University of Queensland	Rockhampton, Toowoomba, Longreach and surrounding districts.
4. Kalgoorlie Rural Clinical School	University of Western Australia	Based at Kalgoorlie- - 1st stage: Kalgoorlie, Geraldton; - 2nd stage: Albany, Bunbury, Busselton.
5. Riverland/NT Rural Clinical School	Flinders University	Riverland, Adelaide Hills/Mallee region, South east region (Mt Gambier), Fleurieu Region, Darwin, Alice Springs, Gove, Katherine.
6. Bairnsdale Rural Clinical School	Monash University	Based at Bairnsdale, extending to Gippsland, Bendigo, Mildura, Traralgon, Latrobe, Sale, Warragul, Loddon-Mallee regions and surrounding districts.
7. Shepparton Rural Clinical School/UDRH	University of Melbourne	Based at Shepparton with a node established at Ballarat, extending to Wangaratta, Bendigo, Warrnambool, Horsham, Benalla, Echuca and surrounding districts.
8. Whyalla Rural Clinical School/UDRH	Adelaide University	Spencer Gulf region, Eyre and Yorke Peninsulas, including Whyalla, Port Augusta, Port Pirie, Coober Pedy, Port Lincoln and surrounding districts.
9. Burnie Rural Clinical School	University of Tasmania	North West Tasmania, based at Burnie, extending to Latrobe, Smithton, Rosebery, Queenstown, King Island and surrounding districts.

Proposed New University Departments of Rural Health

Title	University	Location
1. Tamworth UDRH	Newcastle University	Based at Tamworth and

		surrounding areas.
2. Lismore UDRH	Sydney University in collaboration with Southern Cross University	Based at Lismore, extending to Tweed Heads, Grafton, Moree, Walgett and surrounding districts.

Additional funding will be made available to James Cook University in later years to develop clinical placements in Northern Queensland.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT **Question: E01000219 (a)**

Topic: MEDICAL SCHOOLS – COPY OF SUBMISSIONS

Written Question on Notice

Senator Evans asked:

(a) Can you supply a copy of the original University of Sydney and University of NSW submissions?

(b) What were the grounds given by the assessment panel for rejecting the proposal for a clinical school in Lismore in favour of one in Coffs Harbour? Can the comparative evaluation of the proposals be tabled?

(c) Why do you say that Sydney University 'in a sense' opted for the Coffs Harbour option?

(d) What was the original break up of NSW sought and what process was used to carve it up differently?

Answer:

Further to the answer 219 part (a), the Department has now gained formal agreement from the University of Sydney and the University of New South Wales to provide the Committee with their proposals for the development of rural clinical schools and University Departments of Rural Health.

The proposals are attached.

[Note: attachments have not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 9: HEALTH INVESTMENT .....Question: E01000220

Topic: MEDICAL SCHOOLS - CANBERRA

Written Question on Notice

Senator Evans asked:

(a) What is the current status for the proposal for a medical school in Canberra and which University will it be located at?

(b) Will Canberra Medical School end up the only one without a clinical school because the carve up of NSW has already occurred?

Answer:

(a) The Department provided assistance to the University of Sydney to undertake a Review of its Clinical School currently operating at the Canberra Hospital.

The objectives of the Review were to examine and report on the operation of the current teaching program of the Canberra Clinical School and to determine whether it is appropriate to extend the School's academic program, and, if so, to define what resources would be needed, explore possible long term management models, and determine what time frame would be required for such a development.

The final report has been presented to Professor Gavin Brown, Vice-Chancellor and Principal, The University of Sydney, and subsequently has been released into the public domain.

Discussions between the Commonwealth, ACT Government and the ACT universities concerning the expansion of medical education and training in the ACT and its surrounding districts are continuing.

A summary of the Review's recommendations have been attached for your information (Attachment A).

(b) When the announcement of the proposed locations for the new rural clinical schools and University Departments of Rural Health was made on 6 February 2001 it was indicated that funds will be set aside to assist with the implementation of recommendations arising from the review of the Canberra Clinical School. The Commonwealth's in-principle support for possible development of a Canberra medical school was on the basis that in terms of student intake and curriculum it would have a strong rural focus.

Question: E01000220
Attachment A

SUMMARY OF RECOMMENDATIONS

Recommendation 1:

That the Associate Dean, the staff - medical practitioners and other staff - of the Canberra Clinical School and health service providers in the ACT and surrounding areas of NSW be congratulated on their outstanding achievements in delivering medical education.

Recommendation 2:

a) That the ACT Government recognise that, in addition to the normal allocation of University of Sydney medical students to the Canberra Clinical School, the first cohort of 25 Medical Rural Bonded Scholarship holders will attend the Clinical School in 2001 representing a larger increase in teaching load than any future medical school development would entail;

b) That additional resources be provided as necessary in 2001 to allow facilities and staff to be brought on line expeditiously to fulfil the obligations which were openly accepted by the Chief Minister and the Minister for Health and Aged Care on 16 August 2000;

c) That discussions be held by the University of Sydney, the ACT Government and the NSW Health Department to ensure that adequate education support and facilities are available for the 25 Medical Rural Bonded Scholarship holders.

Recommendation 3:

That the Commonwealth Government, the ACT Government and the NSW Government, as appropriate, make policy decisions as soon as possible regarding the future of the Canberra Clinical School and the establishment of an independent medical school in the ACT.

Recommendation 4:

That the ACT Government institute an immediate process, taking advantage of the advice available from the Canberra Clinical School and the universities, to determine:

a) the case for, and the costs and benefits of, establishing an independent medical school in the ACT;

b) what would be the distinctive characteristics of a Canberra medical school and of its graduates bearing in mind that a significant proportion of its graduates would be destined for practice, by virtue of their bonded scholarships, in remote and rural Australia;

c) the relative merits of the proposals put forward by the Australian National University and the University of Canberra for the establishment of an independent medical school in the ACT; and

d) in the light of the above, what steps should be put in place to begin the planning of the distinctive educational program of the ACT medical school.

Recommendation 5:

That the curriculum of any independent Canberra medical school be based initially on the University of Sydney Medical Program, but that the school develop unique curricular features which would allow educational advantage to be taken of the special educational opportunities available in a Canberra based location.

Recommendation 6:

That, on the conclusion of the process proposed in Recommendation 4 and on the assumption that the ACT Government will wish to proceed with the establishment of an independent Canberra-based medical school, a Planning Dean or Foundation Dean be appointed to develop the details of curriculum, location and governance of the school.

Recommendation 7:

a) That the year (2005 at the earliest) in which an independent Canberra-based medical school enrols its first students be determined by the governing body accepting responsibility for the new medical school; and

b) That students at the Canberra Clinical School who commence as students of the University of Sydney continue to be University of Sydney students proceeding in accordance with the University of Sydney Medical Program and receiving the University of Sydney degrees of Bachelor of Medicine and Bachelor of Surgery on successful completion of their studies.

Recommendation 8:

a) That, given that it is generally accepted that the minimum viable annual intake into a medical school in Australia is between 55 and 60 students and if it is established that the capacity of the Canberra region's health services is adequate to support this number, the intake into an independent Canberra-based medical school be between 55 and 60 students each year (this is, of course, dependent on adequate funding and staffing being available); and

b) That a decision be made by government on the source of the students who are to complement the 25 Medical Rural Bonded Scholarship holders.

Recommendation 9:

That access to NSW Health's services be negotiated for each intake of 25 Medical Rural Bonded Scholarship students plus approximately 35 other students from the Canberra Clinical School and a future Canberra-based medical school.