Community Affairs
Legislation Committee

Examination of Additional Estimates 2000-2001

Additional Information Received
VOLUME 2

Cross portfolio & Outcomes 1 – 2

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

Senator	Quest. No.	Whole of Portfolio	Vol. 2 Page No.
Denman Lundy	1-23 244-47 248-55 109-18 173-75	IT outsourcing	1-71
Evans	262, 262a, 221	Provision of market research reports – private health insurance; Revised guidelines – principles for the conduct of social research Reports on advertising and polling	72-75
Evans	222	Acting positions	76-78
Evans	210	Ministerial expenditure	79-80
Evans	211	Market research	81-85
Evans	212	TV & radio advertising	86
Evans	213-14	Approval of advertising	87-88
Evans	215	Information mail outs	89-92
Evans	216	Government MPs on Committees	93
	Tabled at hearing	Principles for the conduct of systematic social research	94
		Outcome 1: Population Health and Safety	
Denman	126-27	Illicit drugs- heroin price; naltrexone implants	95-96
Denman	128	Illicit drug diversion initiative	97
Evans	129-31	Methadone program	98-100
Harradine	132	Sexual health reference group	101-105
Crowley	133	Public health outcome funding agreement	106-108
Harradine	134	National public health partnership membership	109-111
Harradine	149	Mathatrexate fatalities	112
Crowley	153-59	Gene technology; IOGTR; alleged breaches; GMAC; consultants; contaminated cotton oil	113-123
Crowley	106-107	Starlink – DNA and protein; manufacturers	124-28
West	108	APMAIF	129
West	150	Psuedoephedrine	130
Evans	99	Preventing falls in older people	131
Harradine	100	Family planning	132
Harradine	101	Sexually transmissable infections (STI's)	133
Harradine	102	Methotrexate	134-35
Knowles Evans	151 177-78	Adverse reactions – Celebrex	136-38

Senator	Quest. No.	**Outcome 1: Population Health and Safety [contd]**	Vol. 2 Page No.
Evans	179	Adverse drug reactions - unprocessed reports	139
Harradine	104	Internet availability of contraceptives	140
Evans	223	Q fever	141
West	152	Clinical trials	142
Evans	180	Viagra	143
Evans	181	Naltrexone	144
Evans	224	Tough on drugs	145-46
		Outcome 2: Access to Medicare	
Harradine	140	Medicare payments to midwives	147
Harradine	141	Clarification of MBS definitions	148
Evans	142	PBAC legislation/regulations	149
Evans	143	PBAC nominations	150
Evans	144	PBAC conflict of interest procedure	151-52
Evans	147	Removal of products from PBS	153
Evans	148 184-85	Zyban	154-56
Harradine	103	Medicare statistics on abortion	157-66
Harradine	105	Psychological services	167
Evans	225	PBAC appointments	168
Evans	226	Pharmaceutical industry liaison	169
Evans	227, 146	Benelong group	170-71
Evans	228, 229	Consumer Health Forum	172-74
Evans	230	PBAC Committee role in recommending price	175-76
Evans	231	Pharmaceutical Benefits Pricing Authority (PBPA)	177-78
Evans	232	Launch of the Pfizer product Aricept	179
Evans	176	Celecoxib (Celebrex) sales blowout	180-81
Evans	182	Viagra PBAC application	182
Evans	183	Viagra and dismissal of PBAC Secretary	183
Evans	184	Modified clawback	184-87
Evans	187-88	Assignment of PIP	188
Evans	189	Complex delivery item	189-92
	Tabled at hearing	National Health (Pharmaceutical Benefits) Amendment Regulations 2000 (No. 1)	193-97

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000001**

Topic: IT OUTSOURCING

Written Question on Notice

Senator Denman asked:

(a) What was the initial contract for your outsourcing group estimated to cost?

(b) What were the savings estimates?

(c) What proportion of that contract was your agency responsible for - how much was it going to cost you for your IT services?

(d) Is this sum still an accurate assessment of the value of the contract and estimated savings?

(e) Was there potential for savings only as a group or were savings to be found on an individual basis?

(f) Were savings made on a group basis?

(g) Did your own agency make savings?

(h) What payments have been made by you to date?

(i) What payments have been made by you to CSC Australia which are within the contract?

(j) What payments have been made by you for services not covered by the initial contract?

(k) What is your obligation at the conclusion of the contract to buy back hardware?

(l) What software exposure will you have - ie what is the situation with software licensing and product development provided during the course of the contract?

Answer:

(a) The Department of Health and Aged Care's contract is volume-driven and unit-cost-based. At the time of contract signature (6 December 1999) Health's contract was estimated to be $117.54m over 5 years based on the resource baselines in the Request for Tender.

(b) At the time of contract signature the Department of Health and Aged Care's savings were estimated to be $16.75m, including competitive neutrality and DoFA adjustments, over 5 years.

(c) At the time of contract signature, the Department of Health and Aged Care's portion of the "Health Group's" combined contract values' over a 5-year period was $117.54m, which is subject to the explanation provided in response a).

(d) It is too early in the life of the contract to make a prediction in respect to the Department of Health and Aged Care's ongoing contract value.

Health's experience in the past 12 months of the contract is that contract management costs are considerably higher than the DOFA estimate. If these costs are not able to be materially reduced, there will be no direct savings to Health and Aged Care.

(e) The savings for the Health Group were $54.16m, including competitive neutrality and DoFA adjustments, over 5 years.

Savings on an individual basis were for the Department of Health and Aged Care $16.75m, including competitive neutrality and DoFA adjustments, over 5 years.

(f) See response (e) above.

(g) See response (b) above.

(h) Payments under the Services Agreement to IBM Global Services Australia including additional services has been $11,501,925.75 (GST inclusive).

(i) No payments have been made to CSC Australia by the Department of Health and Aged Care for the provision of outsourced IT services.

(j) All payments to IBM Global Services Australia including additional services are made under the Services Agreement.

(k) The Department of Health and Aged Care has sole discretion to purchase all or any part of the hardware for the then written down book value.

(l) Most software licences are held by the Department of Health and Aged Care. When they are not, the Department is licensed by IBM Global Services Australia to use the software, at no cost until one year after the end of Disengagement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO ....**Question: E01000002**

Topic: IT OUTSOURCING - PROJECT SPECIFICATION

Written Question on Notice (HIC)

Senator Denman asked:

(a) What negotiations took place prior to the requests for tender being developed?

(b) Did OASITO negotiate with your agency separately from, or in conjunction with, external service providers?

(c) Did any consultations take place with OASITO to develop the project specification, as part of the development of the request for tender?

(d) Was there an independent review of your agency prior to the request for tender being developed and released?

(e) Who conducted that review?

(f) Who paid for the review and what did it cost?

(g) What role did OASITO play in the review?

(h) (1) Was there much development of the project specification from the release of the request for tender to the final version of the contract?
(2) Were there significant differences?
(3) Did those differences have an impact on the cost to your agency of outsourcing?

(i) Did your agency have input into the development of the project specification,the request for tender and the final contract?

(j) What processes were put into place to ensure that OASITO understood your business and any particular requirements that you have?

Answer:

(a) The HIC and OASITO discussed the terms of a market testing process prior to the release of an RFT.
The HIC is not aware of any negotiations taking place between OASITO and Vendors prior to the development of the RFT. OASITO conducted discussions with major service providers before the release of the RFT however the HIC is not aware of the full extent of these discussions.

(b) OASITO negotiated in conjunction with the agencies and also held discussions separately from those negotiations. The HIC is not aware of the extent of the discussions that took place in its absence.

(c) Yes.

(d) Yes.

(e) The following reviews were conducted:

- Price Waterhouse Coopers on the reconciliation of the cost models and Statement of Work.
- Price Waterhouse Coopers on the financial risks for capping the financial liability.
- Blake Dawson Waldron on legal risks.
- Mitchell Madison Group on the decision to market test/outsource.

(f) OASITO paid for the Price Waterhouse Coopers and Blake Dawson Waldron reviews. The HIC is not aware of the cost of these reviews. The HIC paid $192,000 for the Mitchell Madison Group review.

(g) OASITO commissioned the reviews by Price Waterhouse Coopers and Blake Dawson Waldron. OASITO reviewed the reports and forwarded only the final versions to the agencies.

The HIC commissioned the Mitchell Madison Group review independently of OASITO.

(h) (1). Yes.

(2). Yes

(3). A series of repricing exercises reduced the projected cost of outsourcing to the agencies.

(i) Yes

(j) As a CAC agency the HIC negotiated with OASITO before and during evaluation to arrive at a position where its interests would be protected during the evaluation process.

A detailed description of the HIC's requirements was set out in the RFT schedules. The HIC also spent considerable time describing its requirements to OASITO.

During the evaluation the HIC's representation in Evaluation Teams and the Evaluation and Steering Committees provided opportunities to protect the HIC's 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

WHOLE OF PORTFOLIO **Question: E01000003**

Topic: IT OUTSOURCING - TENDER EVALUATION

Written Question on Notice (HIC)

Senator Denman asked:

[The Humphry report at p 95 says OASITO's responsibilities in the IT initiative included the following:

i) to provide guidance and assistance to agencies as they participate in tender processes;

ii) to manage the evaluation and negotiation process to ensure fairness and probity;

iii) together with agencies ensure a fair financial evaluation (p 96)]

(a) Who was responsible for evaluating the tenders?

(b) What was the process for evaluating the tenders? Can you outline the steps in the evaluation process?

(c) Was your agency involved in each stage of the process?

(d) Were agencies excluded from any stage in the process?

(e) Was your agency involved in the industry development evaluation stage of the process?

(f) What role did OASITO play in the tender evaluation for your group?

(g) What role did your agency play in the tender evaluation process:
(1) Individually?
(2) Or as a member of a cluster grouping?

(h) What was the extent of that role?

(i) At any time in any of the tender evaluation processes, did the cluster grouping make a recommendation for a particular tenderer which did not conform with OASITO's views?

(j) What was behind the difference of opinion - on what basis was there a difference of opinion?

(k) How was the difference of opinion resolved in each case - what was the outcome?

(l) Were there any interim reports or discussion papers issued by OASITO setting out the different points of view, the basis for the differences and proposed courses of action?

(m) Did OASITO award a contract during any process to an external service provider, which was not the service provider recommended by the agencies as a group?

(n) Did you develop or have any part in developing the tender evaluation reports?

(o) Can you make these available?

Answer:

(a) Responsibility for evaluating the tenders rested with the agencies, OASITO and DoCITA.

(b) The HIC was represented on three Evaluation Teams and the Evaluation and Steering Committees.

The Evaluation Teams assessed bids according to Financial, Corporate and Technical content and provided input to the IT Services Evaluation Report. This report did not rank the bids but identified which tenderers satisfied selection criteria.

The Steering Committee received the report and after approval, submitted the report to the Options Committee.

DoCITA assessed the bids and provided the Options Committee with an Industry Development Evaluation Report.

The Options Committee considered the ID and IT Services Evaluation reports and selected the preferred tenderer.

(c) No. The HIC was not represented in the Industry Development evaluation or on the Options Committee.

(d) Yes. The HIC was not represented in the Industry Development evaluation or on the Options Committee.

(e) No.

(f) OASITO facilitated the process and controlled all interaction, discussion and negotiation with the vendors.

OASITO controlled interaction between the Technical, Corporate and Financial Evaluation Teams, the Evaluation Committee, the Steering Committee and the Options Committee.

(g) (1) The HIC was not represented individually during the evaluation.

(2) The HIC was represented on the Technical, Corporate and Financial Evaluation Teams, and the Evaluation & Steering Committees.

(h) The extent of the HIC's involvement can be summarised as follows:

- Prepare Cost Model.
- Plan and implement strategies for HR transition and related issues.
- Manage communication with agency staff and suppliers.
- Provide staff and prepare materials for due diligence activities, attend technical briefings and interviews.
- Evaluation and negotiation of tenders.
- Prepare evaluation reports.
- Plan and execute Transition.
- Notify OASITO of significant changes to inscope agency infrastructure including hardware, software and services.
- Represent the HIC at the Steering Committee.

(i) No

(j) Not applicable.

(k) Not applicable.

(l) Not to the HIC's knowledge.

(m) No.

(n) Yes.

(o) The Evaluation Report was jointly produced by OASITO, DHAC, MPL and the HIC and contains information confidential to each of these organisations. The HIC is therefore unable to release the full Report without the authority of these organisations. The HIC did, however, provide written authority to OASITO to release the Report to the Committee in full.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question:E01000004**

Topic: IT OUTSOURCING - CONTRACT NEGOTIATIONS

Written Question on Notice (HIC)

Senator Denman asked:

(a) What role did your agency play in contract negotiations?
(b) Did your agency have its own legal representation during the contract negotiation stages?
(c) What components were outsourced - what services does the ESP provide to your agency?
(d) (1) Why was it deemed necessary to sell to the provider the hardware at the commencement of the contract and buy the hardware back from the provider at the end of the contract?
(2) Is this a normal arrangement?
(3) Were both mainframe and desktop components included in the hardware transfer?
(4) What is the life of your mainframe?
(5) Why was the mainframe included in the transfer?
(6) What is the life of a desktop unit?
(7) When did you last replace your desktop units?
(8) When is the external service provider scheduled to replace your desktop units?
(9) What provision is there in your contract for the adoption of new technology?
(10) Are you concerned that your agency may not have the flexibility it once had to adopt new technology or to only do so at additional cost?
(11) What is your agency's potential liability for re-acquisition of assets at the end of the contract?

Answer:

(a) The HIC was represented by a negotiation team which was appointed by the Steering Committee and led by an OASITO provided specialist negotiator.

(b) The HIC was represented by internal legal advisers and commissioned Deacons Graham James to act as external legal advisers.

(c) The HIC outsourced its desktop, midrange and mainframe computer systems as well as its data network, IT Help Desk and bulk mail facility.

(d) (1) Assets were transferred to the ESP as the HIC structured an arrangement whereby it could purchase fully managed IT services. The benefit of buying services is that the risk associated with the ownership of infrastructure is

transferred to the ESP. The HIC Services Agreement provides the ability for the HIC, if it chooses, to acquire all or part of the assets used by the ESP. Such scenarios may include return to in-house or a change in service provision to another supplier.

(2) It is the HIC's understanding that it is not unusual for organisations to transfer ownership of equipment to the ESP when entering an agreement for the provision of managed services such as the HIC's. At disengagement the HIC is not obliged to reacquire the equipment that it transferred to the ESP, however it may do so if it so chooses.

(3) No. Mainframes were transferred to the ESP. The HIC retained leases on desktop equipment and these are managed by the ESP.

(4) The life of the HIC's mainframe computers is dependent of processing requirements and equipment functionality. A life of between 2.5 and 5 years would not be unreasonable in general terms. Because the HIC Services Agreement does not contain an obligation by the HIC to re-acquire assets at then end of the term, the risks associated with the life expectancy of mainframe equipment have been transferred to IBM GSA.

(5) Mainframe equipment was transferred because the HIC requires the provision of a fully managed service. By transferring mainframe assets to the ESP it also transfers complete control and accountability to the ESP. A major cost associated with mainframe processing is for software. The HIC has retained the ability to operate its non-rental software licences throughout the term and beyond.

(6) PCs are refreshed every 3 years.

(7) The HIC uses a continuous 3 year rolling equipment refreshment cycle and not all equipment is refreshed at the same time.

(8) The ESP is scheduled to begin the equipment refresh cycle before 30 June 2001.

(9) The HIC Services Agreement requires the ESP to refresh equipment depending on age. Replacement equipment must be such that it:

- utilises proven current technology,
- takes advantage of technology improvements, and
- provides the best business solution for the HIC including risk considerations.

(10) No. The HIC Services Agreement clearly sets out the ESP's responsibilities.

(11) There is no obligation to purchase the equipment at the end of the contract. However should the HIC so choose it can purchase equipment or take over leases from the ESP.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000005**

Topic: IT OUTSOURCING - CLUSTERING APPROACH

Written Question on Notice (HIC)

Senator Denman asked:

The Humphry Review report concluded that "grouping of agencies has served a useful purpose in enabling economies of scale and providing a coordinated approach to the market" [para 2.1, p11], but that as the Initiative has matured the original rationale for grouping appears to be less relevant:

(a) What is your view on that conclusion - was the clustering of agencies an appropriate approach to the implementation of the policy?

(b) What benefits did the approach deliver?

Answer:

(a) As a CAC agency the HIC must act in its own best interests. The HIC cannot comment on the clustering of other agencies.

(b) The benefit delivered by the approach used was that the HIC was able to test the market together with its primary customer, the Department of Health and Aged Care. This clustering by commonality of portfolio interests rather than a clustering of agencies with like technologies simplified the management process of agreeing to a common solution.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000006**

Topic: IT OUTSOURCING - AGENCY COSTS AND SAVINGS

Written Question on Notice (HIC)

Senator Denman asked:

(a) **What advice did you provide to DOFA/OASITO in relation to potential savings from outsourcing prior to actually outsourcing?**

(b) **Did your estimates of cost savings differ from OASITO's? - If so, what was the quantum of the difference and how were the different figures arrived at?**

(c) **Were OASITO's projections re cost savings accurate? If not, why not?**

(d) **What expenditure was incurred by you in preparation for outsourcing?**

(e) **Has outsourcing been cost effective for your agency?**

(f) **Was any liability for the re-acquisition of assets [guaranteed buy back] at the end of a contract factored into the savings estimates?**

(g) **The Humphry review also stated that there is broad agreement that the Initiative has delivered significant cost savings. However, the Audit report came to a different conclusion, arguing that savings estimates were unreliable and that significant elements of any savings calculation had been omitted. [*] [ie**

(1) the service potential of agency assets on hand at the end of the evaluation period and
(2) the cost of guaranteeing ESP's asset values]: Do you agree that there is broad agreement that the Initiative has delivered significant cost savings?
[*] Audit states at p 14 - "The [financial] evaluations did not consider the service potential associated with agency assets expected to be on hand at the end of the evaluation period under the business-as-usual case, or the costs arising from the Commonwealth's guarantee of ESP's asset values under the outsourcing case."

Answer:

(a) OASITO was provided with advice regarding the level of savings in the Health Cluster Evaluation Report. The figure identified in the report was $20.77m in cash and $16.85m attributed to competitive neutrality.

(b) We understand that OASITO provided an alternate view of cost savings to the Finance Minister. The HIC cannot comment on the nature of OASITO's view or the reason for variation.

(c) It is too early to tell how accurate OASITO's projections were. We expect that at the 2-3 year point of the 5 year contract we will be able to provide an accurate answer.

(d) Approximately $10.31m which includes $4.19m in voluntary redundancy payments.

(e) At this stage it is too early to determine the cost effectiveness of outsourcing.

(f) The HIC does not offer any guarantee to reacquire assets at the end of the contract.

(g) The HIC cannot comment on the level of cost savings achieved by other agencies. It is too early in the life of the HIC Services Agreement to determine the level of savings that may be achieved.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000007**

Topic: IT OUTSOURCING - SERVICE DELIVERY STANDARDS AND SERVICE PROVISION

Written Question on Notice (HIC)

Senator Denman asked:

(a) What service delivery standards were agreed with OASITO by agencies prior to finalisation of contracts?

(b) What negotiations/discussions took place between OASITO and agencies?

(c) Were service delivery standards written into contracts?

(d) How are service delivery standards measured?

(e) How are service delivery standards reported on?

(f) Are service credits being imposed?

(g) Have the contractual arrangements been able to provide adequately for effective levels of service - have you experienced higher levels of service or lower levels of service since your IT requirements have been outsourced?

(h) [if lower levels of service ask]
(1) What have been the major problems?
(2) What has this cost your agency?
(3) Are the costs of any downtime and poor service delivery factored into the savings figures?

(i) [if higher levels of service, ask]:
(1) What are the improvements in the service delivery?
(2) What level of savings have been made?

(j) Has your agency been required to request services which are outside those provided for under the contract?

(k) **Please advise of any 'extra contract' services required and the costs of the provision of those services.**

(l) **Have agency operations been constrained because it is unable to provide a service because it has not been specified under the contract?**

(m) **Would this be because there are either no or limited funds available for extra contract service provision?**

(n) **What outages did you experience during the contract period?**

(o) **What service credits have been imposed as a result of outages?**

Answer:

(a) The agreed service delivery standards were included in the HIC Services Agreement at Schedule 3.

(b) OASITO and the HIC negotiated on a range of issues. These included:

- the HIC's responsibilities as a CAC Agency in the outsourcing process,
- determination of Service Levels,
- cost modelling and cost savings in relation to service standards.

(c) Yes. These are defined as Performance Standards in the HIC's Services Agreement and are described in the Service Levels Schedule.

(d) Service Delivery Standards are individually measured to a degree of detail required by the Service level. Measurements are taken using methods that range from automatic tools to manual tracking of individual events.

(e) The HIC's Services Agreement provides for reporting of service delivery standards to be performed on a monthly basis. Service Reports are provided as aggregated measurements and are grouped by Service Level. The degree of compliance with the service delivery standards is summarised and, if necessary, is supported by a list of incidents that impacted performance during the month.

(f) Yes.

(g) In most cases the quality of services provided by the ESP is similar to that provided by the HIC before outsourcing. While services have improved in some areas, there have also been several major interruptions to service.

(h) (1) The following outlines major problems experienced by the HIC.

- During April 2000 mainframe service was disrupted by the failure of a software component.
- During October 2000 the HIC's operations in Queensland was impacted by two separate and distinct network equipment failures.
- During December 2000 the HIC's South Australian headquarters was disrupted by a network equipment failure.

(2) The cost to the HIC of these incidents has not been calculated. However the HIC's Service Credit regime was designed as a reasonable pre-estimate of the loss likely to be suffered by the HIC as a result of the Contractor's actions

(3) No.

(i) (1) The ESP has improved services in several areas.

- It has improved the availability and performance of the Medicare Direct Billing system by the replacement of Direct Bill servers in all states.
- It has improved stability and performance of the local area network and desktop environment by upgrading server operating environments.
- It has improved mainframe availability.

(2) The level of savings made has not been calculated.

(j) Yes. The HIC's contract with IBM GSA allows for "additional services" to be provided.

(k) As at the end of January 2001, the HIC has committed to purchase additional services from IBM GSA for a range of initiatives that were not included in the HIC's Statement of Work. The value of the new work is $9.7m over a 5 year period. This figure is the sum of $9.5m for services related to the provision of new infrastructure and $0.2m for associated consulting services.

(l) No. As mentioned in Q E0100007(j), the HIC's contract allows it to request its service provider to provide additional services. Alternatively, the HIC may also choose at any time to go to tender for those services.

(m) Not Applicable.

(n) Please refer to part (h) 1) of this question.

(o) During the period from April 2000 and January 2001, the HIC has claimed from IBM GSA financial penalties to a total of $801,505.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000008**

Topic: IT OUTSOURCING - EMPLOYMENT IMPACTS

Written Question on Notice (HIC)

Senator Denman asked:

(a) Has the ESP been able to ensure continuity of contracted staff servicing your agency?

(b) Is there any indication that the changes to the taxation system, which deems contractors/self employed persons to be employees and bound by PAYE requirements, to have impacted on the continuity of service by people employed by ESP's or by sole contractors?

Answer:

(a) Yes.

(b) The HIC is unaware of any such impact on IBM GSA 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

WHOLE OF PORTFOLIO **Question: E01000009**

Topic: IT OUTSOURCING - PRIVACY MATTERS

Written Question on Notice (HIC)

Senator Denman asked:

(a) Were privacy matters a significant issue for you?

(b) What consideration was given to privacy matters
(1) in the request for tender and
(2) in the contract?

(c) What were the cost implications of your privacy requirements?

(d) Were you confident that the ESP had a commitment to and could guarantee the appropriate privacy protections?

Answer:

(a) Yes, privacy has always been vitally important to the HIC.

(b) (1) & (2) The RFT and the Services Agreement contain specific clauses relating to privacy and confidentiality. IBM GSA and each of its subcontractors are required under the SA to sign both Deeds of Undertaking in relation to Personal and Confidential Information, and a Non-Disclosure Undertaking.

(c) Privacy requirements were not separately costed.

(d) Yes. The HIC would not have agreed to proceed with the outsourcing of its IT&T infrastructure unless it had full confidence that the ESP had a commitment to and could support the privacy protections required by the HIC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000010**

Topic: IT OUTSOURCING - INTELLECTUAL PROPERTY MATTERS

Written Question on Notice (HIC)

Senator Denman asked:

(a) Were intellectual property matters an issue for you?

(b) Was this significant?

(c) What consideration was given to IP matters
(1) in the request for tender and
(2) in the contract?

(d) Is it possible to value the IP component of your IT requirements?

Answer:

(a) Yes. IP issues were and remain important to the HIC.

(b) Yes. IP issues were the subject of significant focus throughout the negotiations.

(c) (1)&(2) Clause 25 of the HIC's Services Agreement deals with IP issues. A copy of the draft Services Agreement was included in the request for tender.

(d) The HIC's IP has not been separately valued.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000011**

Topic: IT OUTSOURCING - AUDIT REPORT

Written Question on Notice (HIC)

Senator Denman asked:

(a) The Audit report contained a Whole of Government response to the report - have you any comment on that response and did it accurately reflect your own agency's views on all the findings and recommendations?

(b) If not, where did your views differ from the whole of government response?

Answer:

(a) The HIC does not agree with all of the DOFA Whole of Government responses provided in the Audit Report.

(b) The HIC does not agree with the DOFA Whole of Government response for the following recommendations:

- **Recommendation No.8**
  ANAO recommends that, for future IT outsourcing tenders, relevant agencies enhance transparency and accountability of decision making in the tender process by incorporating into the evaluation planning process consideration of the means by which tenderers will be ranked in terms of the best combination of value for money/cost savings and industry development criteria.

  Disagree: DOFA whole-of-government response

  HIC Response: The HIC supports the ranking of tenderers by the agencies.

- **Recommendation No.11**
  ANAO recommends that relevant agencies ensure that future IT outsourcing agreements complement the Government's whole-of-Government telecommunication policy by stipulating a requirement that:

  a) relevant services be provided to agencies in accordance with whole-of-Government telecommunications arrangements, including that services must be procured under a whole-of-Government Head Agreement supported by appropriate reporting arrangements; and

b) all telecommunications services be procured in the name of the Commonwealth unless otherwise agreed in writing by the Office for Government Online.

Agree: DOFA whole-of-government response – Part (a)

Agree with qualification: DOFA whole-of-government response - Part (b)

HIC Response: The HIC disagrees with the Audit Report recommendation. The HIC Board of Commissioners has specific duties under the Commonwealth Authorities and Companies Act to act in the best interests of the HIC. The HIC can only procure a service under a whole-of-government arrangement if it is in the best interests of the HIC to so do.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000012**

Topic: IT OUTSOURCING – HUMPHRY REVIEW

Written Question on Notice (HIC)

Senator Denman asked:

(a) **What is your reaction to the findings of the Humphry review?**

(b) **Did your agency have input into the Humphry review?**

(c) **Was that input written or oral - did you meet with Mr Humphry?**

(d) **Were any meeting notes or minutes taken or any documentation at all developed out of these meetings?**

(e) **Did the secretariat discuss any meeting notes with you - distribute any meeting notes for your comments?**

(f) **Would it surprise you to know that there is no documentation standing behind the findings and recommendations of the Humphry review?**

(g) **Will your agency continue to outsource at the conclusion of the present contract?**

(h) **What implications will it have for your agency if you decide not to continue with the present contract provider?**
 (1) What are the financial implications?
 (2) What are the hardware and software implications?

Answer:

(a) The major focus of the Humphry Review was on the implementation risks associated with IT infrastructure outsourcing. As the HIC had completed its transition of IT infrastructure to IBM GSA prior to the release of the Review, the HIC has no comments to make on its findings.

(b) Yes.

(c) It was oral. The Managing Director of the HIC, Dr Harmer met with Mr Humphry on 30 November 2000.

(d) Not by Dr Harmer. The HIC is not aware of what records were kept by Mr Humphry.

(e) No.

(f) Yes.

(g) No decision has been made. As the contract does not conclude until 31 March 2005, it is still too early to make such a decision.

(h) (1) The long term cost/benefit associated with changing the current service provider cannot be determined at this point as the structure of alternative offers is not known.

(2) A decision regarding the HIC's provision of IT & T services beyond the current contract has not been made. However if it does decide to disengage from its current ESP the HIC may, at its option, purchase all or any part of the equipment for the written down book value and request the ESP to assign any equipment leases to the HIC effective as at the termination date.

Provision of software is not seen as an inhibitor as most software licensing is conducted in the HIC's name. Should the HIC change provider there would be no restriction to the required software licensing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000013**

Topic: IT OUTSOURCING - PROJECT SPECIFICATION

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) What negotiations took place prior to the requests for tender being developed?

(b) Did OASITO negotiate with your agency separately from, or in conjunction with, external service providers?

(c) Did any consultations take place with OASITO to develop the project specification, as part of the development of the request for tender?

(d) Was there an independent review of your agency prior to the request for tender being developed and released?

(e) Who conducted that review?

(f) Who paid for the review and what did it cost?

(g) What role did OASITO play in the review?

(h) (1) Was there much development of the project specification from the release of the request for tender to the final version of the contract?
(2) Were there significant differences?
(3) Did those differences have an impact on the cost to your agency of outsourcing?

(i) Did your agency have input into the development of the project specification, the request for tender and the final contract?

(j) What processes were put into place to ensure that OASITO understood your business and any particular requirements that you have?

Answer:

(a) To Medibank Private's knowledge, no negotiations took place with tenderers prior to the RFT being developed. Discussions, rather than negotiations, took place with OASITO to ensure Medibank Private understood the process and the nature of Medibank Private's involvement should it decide to participate.

(b) Discussions with OASITO took place but no external service providers were present.

(c) Medibank Private developed its own specification independently, and with OASITO's assistance ensured that Medibank Private's requirements were represented in a suitable form for inclusion in the tender specifications.

(d) No.

(e) Not applicable.

(f) Not applicable.

(g) Not applicable.

(h) (1) No. Changes were very limited and not significant in terms of Medibank Private's total IT&T activity.
(2) No. There was a minor change to scope to include database administration and some printing services.
(3) Yes – the change of scope marginally altered cost baselines.

(i) Yes, Medibank Private had input into the specification to the extent it related to Medibank Private, and also contributed to the development of the request for tender and the services agreement.

(j) Medibank Private was part of the process as a participating observer. It was represented on the Evaluation Teams, the Evaluation Committee and the Steering Committee and was involved in discussions with OASITO throughout the 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

WHOLE OF PORTFOLIO **Question: E01000014**

Topic: IT OUTSOURCING - TENDER EVALUATION

Written Question on Notice (Medibank Private)

Senator Denman asked:

[The Humphry report at p95 says OASITO's responsibilities in the IT initiative included the following:
(i) to provide guidance and assistance to agencies as they participate in tender processes;
(ii) to manage the evaluation and negotiation process to ensure fairness and probity;
(iii) together with agencies ensure a fair financial evaluation (p96)]

(a) Who was responsible for evaluating the tenders?

(b) What was the process for evaluating the tenders? Can you outline the steps in the evaluation process?

(c) Was your agency involved in each stage of the process?

(d) Were agencies excluded from any stage in the process?

(e) Was your agency involved in the industry development evaluation stage of the process?

(f) What role did OASITO play in the tender evaluation for your group?

(g) What role did your agency play in the tender evaluation process:
(1) Individually?
(2) Or as a member of a cluster grouping?

(h) What was the extent of that role?

(i) At any time in any of the tender evaluation processes, did the cluster grouping make a recommendation for a particular tenderer which did not conform with OASITO's views?

(j) What was behind the difference of opinion – on what basis was there a difference of opinion?

(k) How was the difference of opinion resolved in each case – what was the outcome?

(l) Were there any interim reports or discussion papers issued by OASITO setting out the different points of view, the basis for the differences and proposed courses of action?

(m) Did OASITO award a contract during any process to an external service provider, which was not the service provider recommended by the agencies as a group?

(n) Did you develop, or have any part in developing the tender evaluation reports?

(o) Can you make these available?

Answer:

(a) Three Evaluation Teams – Technical, Financial and Corporate – made a recommendation to the Evaluation Committee, which in turn made a recommendation to the Steering Committee for a decision. The final decision whether Medibank Private would proceed rested with the Board of Medibank Private.

(b) The three Evaluation Teams reviewed the tender responses. Clarification questions were raised and answered by the tenderers. Clarification meetings were also held with all tenderers. The Evaluation Committee made recommendations to the Steering Committee. The Options Committee then considered the Steering Committee recommendations in the light of industry development proposals.

(c) Yes, except that Medibank Private was not represented on the Options Committee.

(d) Medibank Private is not budget funded and was not required to include industry development provisions in its services agreement. It did not participate in that part of the evaluation process.

(e) No.

(f) OASITO's role was process facilitation and advice, assisted by OASITO's external advisers Blake Dawson Waldron and Shaw Pitman.

(g) (1) Not applicable.
(2) Medibank Private participated in the three Evaluation Teams, Evaluation Committee and Steering Committee as a participating observer.

(h) Medibank Private was a participating observer.

(i) Not to our knowledge.

(j) Not applicable.

(k) Not applicable.

(l) Not to our knowledge.

(m) Not to our knowledge.

(n) Yes.

(o) In the context of the possible release of the evaluation reports, Medibank Private has expressed its concerns to OASITO about the release of commercial in confidence information and information that may prejudice the security of Medibank Private's systems.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E010000015**

Topic: IT OUTSOURCING - CONTRACT NEGOTIATIONS

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) What role did your agency play in contract negotiations?

(b) Did your agency have its own legal representation during the contract negotiation stages?

(c) What components were outsourced – what services does the ESP provide to your agency?

(d) (1) Why was it deemed necessary to sell to the provider the hardware at the commencement of the contract and buy the hardware back from the provider at the end of the contract?
(2) Is this a normal arrangement?

(e) Were both mainframe and desktop components included in the transfer?

(f) What is the life of your mainframe?

(g) Why was the mainframe included in the transfer?

(h) What is the life of a desktop unit?

(i) When did you last replace your desktop units?

(j) When is the external service provider scheduled to replace your desktop units?

(k) What provision is there in your contract for the adoption of new technology?

(l) Are you concerned that your agency may not have the flexibility it once had to adopt new technology or to only do so at additional cost?

(m) What is your agency's potential liability for re-acquisition of assets at the end of the contract?

Answer:

(a) Medibank Private was represented at contract negotiation meetings by Medibank Private members of the Evaluation Teams, the Evaluation Committee or the Steering Committee.

(b) Minter Ellison acted as legal advisers to Medibank Private throughout the tender evaluation and contract negotiation processes.

(c) The services agreement executed on 6 December 1999 initially covered mainframe and midrange services. It did not cover LAN, desktop or telecommunications services.

(d) (1) This is not an issue for Medibank Private, as Medibank Private's IT&T services were previously provided by the Health Insurance Commission, via the Health Insurance Commission mainframe. Medibank Private did not sell any assets under the original scope of the services agreement.

(2) Not applicable.

(e) Under the original scope of the services agreement (which Medibank Private has subsequently extended), desktop services were not included.

(f) Not applicable.

(g) Not applicable.

(h) Not applicable.

(i) Not applicable.

(j) Not applicable.

(k) The services agreement provides for Medibank Private to receive the benefits of significant advances in technology (clause 12.9).

(l) No. Medibank Private believes it is adequately protected under the outsourced arrangements.

(m) There is no liability for re-acquisition of assets.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000016**

Topic: IT OUTSOURCING - CLUSTERING APPROACH

Written Question on Notice (Medibank Private)

Senator Denman asked:

The Humphry Review report concluded that "grouping of agencies has a useful purpose in enabling economies of scale and providing a co-ordinated approach to the market" [para 2.1, p11], but that as the Initiative has matured the original rationale for grouping appears to be less relevant.

(a) What is your view on that conclusion – was the clustering of agencies an appropriate approach to the implementation of the policy?

(b) What benefits did the approach *[sic]*.

Answer:

(a) Medibank Private's IT&T services were previously provided by the Health Insurance Commission, so it was advantageous to participate as an observer in the outsourcing process with the Health Insurance Commission.

(b) The grouping approach enabled Medibank Private to finalise separation from the Health Insurance Commission and successfully contract with a new supplier.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000017**

Topic: IT OUTSOURCING – AGENCY COSTS & SAVINGS

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) What advice did you provide to DOFA/OASITO in relation to potential savings from outsourcing prior to actually outsourcing?

(b) Did your estimates of cost savings differ from OASITO's? If so, what was the quantum of the difference and how were the different figures arrived at?

(c) Were OASITO's projections re cost savings accurate? If not, why not?

(d) What expenditure was incurred by you in preparation for outsourcing?

(e) Has outsourcing been cost effective for your agency?

(f) Was any liability for the re-acquisition of assets [guaranteed buy back] at the end of a contract factored into the savings estimates?

(g) The Humphry review also stated that there is a broad agreement that the Initiative has delivered significant cost savings. However, the Audit report came to a different conclusion, arguing that savings estimates were unreliable and that significant elements of any savings calculation had been omitted(*) [ie (1) the service potential of agency assets on hand at the end of the evaluation period and (2) the cost of guaranteeing ESP's asset values]. Do you agree that there is broad agreement that the Initiative has delivered significant cost savings?
(*) Audit states at p14 – "The [financial] evaluations did not consider the service potential associated with agency assets expected to be on hand at the end of the evaluation period under the business-as-usual case, or the costs arising from the Commonwealth's guarantee of ESP's asset values under the outsourcing case."

Answer:

(a) Medibank Private was not required to disclose its cost baseline as part of the evaluation process.

(b) Medibank Private developed its own cost baseline.

(c) Not applicable.

(d) Expenditure was incurred for external legal and technical advisers. In addition, internal resources required to prepare the request for tender, calculate the cost baseline, and otherwise prepare for the outsourcing process. Medibank Private employees and contractors were involved in evaluation and contract negotiations. Approximately 12 employees participated in the evaluation process, and 2 senior managers sat on the Steering Committee.

(e) Yes. Medibank Private is satisfied with the outcomes to date. Significant changes in Medibank Private's business since December 1999, including the impact of Lifetime Health Cover and its sales intensity program led to large increases in membership and related transaction volumes. Medibank Private is continuing to monitor closely the costs and benefits associated with outsourcing its IT&T services.

(f) Not applicable.

(g) 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

WHOLE OF PORTFOLIO **Question: E01000018**

Topic: IT OUTSOURCING – SERVICE DELIVERY STANDARDS & SERVICE PROVISIONS

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) What service delivery standards were agreed with OASITO by agencies prior to finalisation of contracts?

(b) What negotiations/discussions took place between OASITO and agencies?

(c) Were service delivery standards written into contracts?

(d) How are service delivery standards measured?

(e) How are service delivery standards reported on?

(f) Are service credits being imposed?

(g) Have the contractual arrangements been able to provide adequately for effective levels of service – have you experienced higher levels of service or lower levels of service since your IT requirements have been outsourced?

(h) [If lower levels of service, ask]
(1) What have been the major problems?
(2) What has this cost your agency?
(3) Are the costs of any downtime and poor service delivery factored into the savings figures?

(i) [If higher levels of service, ask]
(1) What are the improvements in the service delivery?
(2) What level of savings have been made?

(j) Has your agency been required to request services which are outside those provided for under the contract?

(k) Please advise of any "extra contract" services required and the costs of the provision of those services.

(l) Have agency operations been constrained because it is unable to provide a service because it has not been specified under the contract?

(m) Would this be because there are either no or limited funds available for extra contract service provision?
(n) What outages did you experience during the contract period?

(o) What service credits have been imposed as a result of outages?

Answer:

(a) Medibank Private prepared its own service delivery requirements for inclusion in the Medibank Private Statement of Work which formed part of the services agreement.

(b) Discussions took place with OASITO between 16 February 1999 and 6 December 1999 in Evaluation Teams, Evaluation Committee and Steering Committee.

(c) Yes. Service levels were defined in Schedule 3 of the services agreement.

(d) Service delivery standards are measured against service levels, which are set out in Schedule 3 of the services agreement.

(e) Service delivery standards are the subject of a series of daily and monthly reports by the Contractor to Medibank Private.

(f) Service credits have been imposed, but these have been insignificant in the overall scope of the services agreement.

(g) Medibank Private is currently satisfied with the levels of service provided under the services agreement. Volumes have increased significantly since signing the services agreement.

(h) (1) Not applicable.
(2) Not applicable
(3) Not applicable

(i) (1) Not applicable.
(2) Not applicable.

(j) No additional services have been required to date.

(k) Not applicable.

(l) No.

(m) Not applicable.

(n) There have been a couple of short mainframe outages to date. None have occurred in the last few months.

(o) This information is commercial in confidence between the parties to the services agreement. Medibank Private is not a budget funded agency.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000019**

Topic: IT OUTSOURCING - EMPLOYMENT IMPACTS

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) Has the ESP been able to ensure continuity of contracted staff servicing your agency?

(b) Is there any indication that the changes to the taxation system, which deems contractors/self employed persons to be employees and bound by PAYE requirements, to have impacted on the continuity of service by people employed by ESP's or by sole contractors?

Answers:

(a) Medibank Private is satisfied with the level of continuity of staff.

(b) Not to our knowledge.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000020**

Topic: IT OUTSOURCING – PRIVACY MATTERS

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) Were privacy matters a significant issue for you?

(b) What consideration was given to privacy matters (1) in the request for tender and (2) in the contract?

(c) What were the cost implications of your privacy requirements?

(d) Were you confident that the ESP had a commitment to and could guarantee the appropriate privacy protections?

Answer:

(a) Yes.

(b) Data security, confidentiality and privacy were dealt with in clauses 21, 22 and 24 respectively of the services agreement. A draft services agreement was included as part of the request for tender.

(c) These costs were not separately identified, as these requirements were part of the overall technical solution to ensure compliance with Medibank Private policy.

(d) 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

WHOLE OF PORTFOLIO **Question: E01000021**

Topic: IT OUTSOURCING - INTELLECTUAL PROPERTY

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) Were intellectual property matters an issue for you?

(b) Was this significant?

(c) What consideration was given to IP matters (1) in the request for tender and (2) in the contract?

(d) Is it possible to value the IP component of your IT requirements?

Answer:

(a) Yes.

(b) Yes.

(c) Intellectual property was dealt with in clause 25 of the services agreement. A draft services agreement was included as part of the request for tender.

(d) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000022**

Topic: IT OUTSOURCING - AUDIT REPORT

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) The Audit report contained a Whole of Government response to the report – have you any comment on that response and did it accurately reflect your own agency's views on all the findings and recommendations?

(b) If not, where did your views differ from the Whole of Government response?

Answers:

(a) Medibank Private participated in the process as a participating observer and as such has no comment to make.

(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

WHOLE OF PORTFOLIO **Question: E01000023**

Topic: IT OUTSOURCING - HUMPHRY REVIEW

Written Question on Notice (Medibank Private)

Senator Denman asked:

(a) What is your reaction to the findings of the Humphry review?

(b) Did your agency have input into the Humphry review?

(c) Was that input written or oral – did you meet with Mr Humphry?

(d) Were any meeting notes or minutes taken or any documentation at all developed out of these meetings?

(e) Did the secretariat discuss any meeting notes with you – distribute any meeting notes for your comments?

(f) Would it surprise you to know that there is no documentation standing behind the findings and recommendations of the Humphry review?

(g) Will your agency continue to outsource at the conclusion of the present contract?

(h) What implications will it have for your agency if you decide not to continue with the present contract provider?
(1) What are the financial implications?
(2) What are the hardware and software implications?

Answer:

(a) Medibank Private participated in the process as a participating observer and as such has no comment to make. Medibank Private concluded a satisfactory outsourcing agreement from the process.

(b) No.

(c) Not applicable.

(d) Not applicable.

(e) Not applicable.

(f) Medibank Private did not participate in the Humphry review and has no comment.

(g) The initial term of the current Agreement is scheduled to run until December 2004, and may be extended until December 2008. Medibank Private will decide closer to the termination date, based on commercial considerations, whether it will continue to outsource its IT&T services to IBM GSA or another supplier.

(h) The implications of not continuing with the present contract provider would depend on the alternative solution selected and Medibank Private's needs at that time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000244**

Topic: IT OUTSOURCING

Written Question on Notice

Senator Lundy asked:

(a) What negotiations took place prior to the requests for tender being developed?

(b) Did OASITO negotiate with your agency separately from, or in conjunction with, external service providers?

(c) Did any consultations take place with OASITO to develop the project specification, as part of the development of the request for tender?

(d) Was there an independent review of your agency prior to the request for tender being developed and released?

(e) Who conducted that review?

(f) Who paid for the review and what did it cost?

(g) What role did OASITO play, if any, in the review?

Answer:

(a) The Department of Health and Aged Care undertook no negotiations prior to the request for tender being developed.

(b) This question should be directed to OASITO.

(c) Yes. Extensive consultations took place with OASITO.

(d) Yes.

(e) PriceWaterhouseCoopers.

(f) The Office of Asset Sales and IT Outsourcing paid for the review. The cost of the review is a matter for the Office of Asset Sales and IT Outsourcing.

(g) The Office of Asset Sales and IT Outsourcing managed the review in consultation with the 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

WHOLE OF PORTFOLIO **Question: E01000245**

Topic: IT OUTSOURCING – PROJECT SPECIFICATION

Written Question on Notice

Senator Lundy asked:

(a) Was there much development of the project specification from the release of the request for tender to the final version of the contract?

(b) Were there significant differences?

(c) Did those differences have an impact on the cost to your agency of outsourcing?

(d) Did your agency have input into the development of the project specification, the request for tender and the final contract?

(e) What processes were put into place to ensure that OASITO understood your business and any particular requirements that you have?

Answer:

(a) Yes.

(b) Yes. The Department of Health and Aged Care removed the voice services component from the request for tender.

(c) Yes. The removal of voice services reduced the Department of Health and Aged Care cost baseline by $14.6m.

(d) Yes.

(e) The Department of Health and Aged Care described its business processes in a comprehensive schedule to the request for tender. In addition the Department of Health and Aged Care went to considerable lengths to brief the Office of Asset Sales and IT Outsourcing on the business

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000246**

Topic: IT OUTSOURCING – DESKTOP UNITS

Written Question on Notice

Senator Lundy asked:

(a) What is the life of a desktop unit?

(b) When did you last replace your desktop units?

(c) When is the external service provider scheduled to replace your desktop units?

(d) What provision is there in your contract for the adoption of new technology?

(e) Are you concerned that your agency may not have the flexibility it once had to adopt new technology or to only do so at additional cost?

(f) What is your agency's potential liability for re-acquisition of assets at the end of the contract?

Answer:

(a) Under the Department of Health and Aged Care's contract the "life of a desktop unit" is three years.

(b) The Department of Health and Aged Care replaced its desktop units in the 2nd quarter of 1998.

(c) The first desktop refresh within the Department of Health and Aged Care is in train now, and is expected to run for several months.

(d) The contract contains specific provisions that requires the contractor to actively participate in activities related to introducing new technologies, including also a requirement to provide the Department with an annual Technology Plan.

(e) No.

(f) The Department of Health and Aged Care has sole discretion to purchase all or any part of the hardware for the then written down value.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000247**

Topic: IT OUTSOURCING – APPLICATIONS DEVELOPMENT

Written Question on Notice

Senator Lundy asked:

To what extent is your contract for IT infrastructure related to your contract for applications development?

Answer:

The Department of Health and Aged Care has not outsourced its applications development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000248**

Topic: IT OUTSOURCING – AGENCY COSTS AND SAVINGS

Written Question on Notice

Senator Lundy asked:

(a) What advice did you provide to DOFA/OASITO in relation to potential savings from outsourcing prior to actually outsourcing?

(b) Did your estimates of cost savings differ from OASITO's? – If so, what was the quantum of the difference and how were the different figures arrived at?

(c) Were OASITO's projections re cost savings accurate? If not, why not?

(d) What expenditure was incurred by you in preparation for outsourcing?

(e) Has outsourcing been cost effective for your agency?

(f) Was any liability for the re-acquisition of assets [guaranteed buy back] at the end of a contract factored into the savings estimates?

Answer:

(a) None.

(b) The Department of Health and Aged Care had no formal estimates of savings prior to the request for tender release.

(c) The Department of Health and Aged Care had no formal projections of cost savings prior to the request for tender release.

(d) The Department of Health and Aged Care’s expenditure for the period of July 1998 to June 2000 was $10,019,942.84

This figure includes staffing costs of $4,118,919.39 and Voluntary Redundancies of $5,901,023.45

(e) The Department of Health and Aged Care has found that a combination of outsourcing and the introduction of chargeback has made previously invisible IT costs visible to the users. This has resulted in cost effective and appropriate decision-making regarding the consumption of IT services.

(f) Yes it was included.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000249**

Topic: IT OUTSOURCING – AGENCY COSTS AND SAVINGS

Written Question on Notice

Senator Lundy asked:

(a) What service delivery standards were agreed with OASITO by agencies prior to finalisation of contracts? What negotiations/discussions took place between OASITO and agencies?

(b) Were service delivery standards written into contracts?

(c) How are service delivery standards measured?

(d) How are service delivery standards reported on?

(e) Are service credits being imposed?

Answer:

(a) The Department of Health and Aged Care with the assistance of OASITO negotiated with IBM GSA a schedule to the Services Agreement "Schedule 3 Service Level and Service Credits.

(b) Yes.

(c)

(d) For the Department of Health and Aged Care Service Levels are measured on a "platform by platform" basis.

IBM GSA must monitor the Service Levels outlined in the Service Level Schedule using tracking tools, which may range from widely available measures to manual tracking of incident reports.

(e) IBM GSA reports to the Department of Health and Aged Care the attainment or non-attainment of each Service Level in respect to each billing period. In addition to the definitions identified for each individual Service Level, the Department of Health and Aged Care and IBM GSA have developed a reporting procedure that details the framework for reporting such Service Levels that identifies how IBM GSA measures and applies the measurement framework to the reports tabled at the end of the billing period.

(f) 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

WHOLE OF PORTFOLIO **Question: E01000250**

Topic: IT OUTSOURCING – SERVICE DELIVERY STANDARDS AND SERVICE PROVISION
Written Question on Notice

Senator Lundy asked:

(a) What specific problems have attracted 'service credits', and how many and how much (in $ value) to each problem

(b) What outages did you experience during the contract period?

(c) What service credits have been imposed as a result of outages?

(d) What has this cost your agency overall?

(e) Are the costs of any downtime and poor service delivery factored into the savings figures?

(f) What proportion of savings (if any) are attributable to reduced invoice payments as a result of service credits?

(g) Has your agency been required to request services which are outside those provided for under the contract?

(h) Please advise of any 'extra contract' services required and the costs of the provision of those services.

(i) Have agency operations been constrained because it is unable to provide a service because it has not been specified under the contract.

(j) Would this be because there are either no or limited funds available for extra contract service provision?

Answer:

(a) To date the Department of Health and Aged Care has agreed Service Credits for the month of June 2000. The value of those Services Credits were, Telecommunications $34,090.84, Help Desk - Problem Closure Time $20,000.00, Hard MACs $3,000.00 and Mainframe Availability $1,273.00.

(b) The Department of Health and Aged Care has experienced intermittent network outages during January and early February 2001. Apart from a single mainframe outage during October 2000 there have been no other significant outages.

(c) To date the Department of Health and Aged Care has imposed $58,363.84 for Service Credits for the month of June 2000. The Department is currently reviewing Service Credits for subsequent periods.

(d) The Department of Health and Aged Care is unable to estimate this cost.

(e) No.

(f) None.

(g) No.

(h) None

(i) No.

(j) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000251**

Topic: IT OUTSOURCING – EMPLOYMENT IMPACTS

Written Question on Notice

Senator Lundy asked:

(a) Has the ESP been able to ensure continuity of contracted staff servicing your agency?

(b) Is there any indication that the changes to the taxation system, which deems contractors/self employed persons to be employees and bound by PAYE requirements, to have impacted on the continuity of service by people employed by ESP's or by sole contractors?

Answer:

(a) Yes.

(b) This is not visible to the 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

WHOLE OF PORTFOLIO **Question: E01000252**

Topic: IT OUTSOURCING – PRIVACY MATTERS

Written Question on Notice

Senator Lundy asked:

(a) Were privacy matters a significant issue for you?

(b) What consideration was given to privacy matters 1) in the request for tender and 2) in the contract?

(c) What were the cost implications of your privacy requirements?

(d) Were you confident that the ESP had a commitment to and could guarantee the appropriate privacy protections?

(e) What action has the Audit Report prompted with the department in relation to privacy?

(f) What action has the Humphry Review prompted with the department in relation to privacy?

Answer:

(a) Yes, The Department of Health and Aged Care's contractual requirements were met by IBM Global Services Australia.

(b) Standard Commonwealth privacy requirements were included in both the request for tender and the Services Agreement. Breach of privacy requirements is specifically included in the Services Agreement as grounds for termination.

(c) Any additional costs are not visible to the Department of Health and Aged Care.

(d) Yes.

(e) None was necessary.

(f) None was 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

WHOLE OF PORTFOLIO **Question: E01000253**

Topic: IT OUTSOURCING – INTELLECTUAL PROPERTY MATTERS

Written Question on Notice

Senator Lundy asked:

(a) Were intellectual property matters an issue for you?

(b) Was this significant?

(c) What consideration was given to IP matters (i) in the request for tender and (ii) in the contract?

(d) Is it possible to value the IP component of your IT requirements?

(e) Can you advise of the IP arrangements relating to applications developed on behalf of the department by contractor/s?

Answer:

(a) Yes, and the Commonwealth's contractual requirements were met by IBM GSA. In particular Health was concerned to ensure that it had access to material which would be needed by a future new supplier of services.

(b) Yes. A particular focus was given to this matter during the evaluation of tenders and the negotiation of contracts to identify material which would be required by Health to engage a new services provider.

(c) The Commonwealth's standard intellectual property provisions were included in both the request for tender and the Services Agreement.

(d) No.

(e) The Department of Health and Aged Care has not outsourced its Applications Development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000254**

Topic: IT OUTSOURCING – AUDIT REPORT

Written Question on Notice

Senator Lundy asked:

(a) The Audit report contained a Whole of Government response to the report – have you any comment on that response and did it accurately reflect your own agency's views on all the findings and recommendations?

(b) If not, where did your views differ from the whole of government response?

Answer:

(a) The Department of Health and Aged Care did not provide any input into the Whole-of-Government response.

(b) The Department of Health and Aged Care did not provide any input into the Whole-of-Government response.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000255**

Topic: IT OUTSOURCING – HUMPHRY REVIEW

Written Question on Notice

Senator Lundy asked:

(a) What is your reaction to the findings of the Humphry review?

(b) Did your agency have input into the Humphry review?

(c) Was that input written or oral – did you meet with Mr Humphry?

(d) Were any meeting notes or minutes taken or any documentation at all developed out of these meetings?

(e) Did the secretariat discuss any meeting notes with you – distribute any meeting notes for your comments?

(f) Would it surprise you to know that there is no documentation standing behind the findings and recommendations of the Humphry review?

(g) Will your agency continue to outsource at the conclusion of the present contract?

(h) What implications will it have for your agency if you decide not to continue with the present contract provider?

(i) What are the financial implications?

(j) What are the hardware and software implications?

Answer:

(a) The focus of the Humphry Review was on the implementation risks associated with IT infrastructure outsourcing. As Health has completed its transition of IT infrastructure to IBM GSA, much of the Review's material is of little direct relevance.

Health worked closely with the Humphry team and it was pleasing to see many of Health's strategies and ideas reflected in the Review.

(b) Yes.

(c) The Department of Health and Aged Care spoke with Mr Humphry and separately spoke with Mr Prior.

(d) Yes.

(e) No.

(f) The Department of Health and Aged Care has no view on this.

(g) The Department of Health and Aged Care believes that it is too early to make a judgement on this matter.

(h) The Department of Health and Aged Care believes that it is too early to make a judgement on this matter.

(i) The Department of Health and Aged Care believes that it is too early to make a judgement on this matter.

(j) None that the Department of Health and Aged Care can ascertain.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000109**

Topic: IT OUTSOURCING – EVALUATION, STEERING & OPTIONS COMMITTEES

Hansard Page: CA 113

Senator Lundy asked:

Names of the Evaluation Committee, Steering Committee and Options Committee for the Health Group.

Answer:

Steering Committee

Department of Health and Aged Care
Ian Heath – July 1998 to July 1999
Neville Tomkins – July 1998 to December 1999
Lyn O'Connell – July 1999 to December 1999.

The Health Insurance Commission has provided the following response:
Health Insurance Commission
Peter Bunting

Medibank Private Limited
Chris Farrelley
Di Jay

Evaluation Committee

Department of Health and Aged Care
Peter Moran – July 1998 to December 1999
Lyn O'Connell – July 1998 to July 1999

The Health Insurance Commission has provided the following response:

Health Insurance Commission
Peter Hatch
David Num

Medibank Private Limited
Brian Peppy
Gil Buerdlmayer

Question:E01000109

Options Committee

The Department of Health and Aged Care understands the following to be members of the Options Committee.

Mr Mike Hutchinson
Dr Rodney Badger
Mr Alan Evans
Mr Alister Maitland
Mr Geoffrey McIntyre
Mr Andrew Podger

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000110**

Topic: IT OUTSOURCING – EVALUATION TEAMS

Hansard Page: CA 113

Senator Lundy asked:

Names, title and levels of the Health and Aged Care members on various evaluation teams.

Answer:

Technical
Robert West – Director, Contestability Branch
Mark Donnelly – Director, Contestability Branch
Steve Adams – Assistant Director, Contestability Branch

Financial
Vipan Mahajan – Director, Contestability Branch
John Norman - Director, Contestability Branch
Steven Schultz – Contractor, Contestability Branch

Corporate
Peter Moran, Assistant Secretary, Contestability Branch
Geoff Barnett – Assistant Director, Contestability Branch
Geoff Rodwell – Contractor, Contestability Branch
Denis Dobie – Contractor, Contestability Branch

During the period of the evaluation numerous Commonwealth Officers and Contractors participated on the various Health Evaluation teams on an “as-needed” basis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000111**

Topic: IT OUTSOURCING – OPTIONS COMMITTEE

Hansard Page: CA 114

Senator Lundy asked:

The membership of the Options Committee, including those who were not formal members of the Committee, but may be part of the committee in some other capacity (eg BDW, SPPT etc.).

Answer:

Refer to Question E01000109.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000112**

Topic: IT OUTSOURCING – OPTIONS COMMITTEE

Hansard Page: CA 116

Senator Lundy asked:

Was there any involvement on the Options Committee or Steering Committee from members of the private organisations/firms?

Answer:

Options Committee

Mr Alister Maitland
Mr Geoffrey McIntyre

Steering Committee

The Department of Health and Aged Care understands various advisers attended but were not members of 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

WHOLE OF PORTFOLIO **Question: E01000113**

Topic: IT OUTSOURCING – CORRESPONDENCE FROM DOFA/OASITO

Hansard Page: CA 118

Senator Lundy asked:

In addition to the Prime Minister letter of late 1998, was there any correspondence either from the Minister for Finance or OASITO, setting out the roles and responsibilities of members of the outsourcing project?

Answer:

Yes, a copy of the letter is attached.

M9900411 AS-EX

FOR YOUR INFORMATION
Please file and enter the departmental file number on the MIRACLS system.

MINISTER FOR FINANCE AND ADMINISTRATION

RECEIVED 20 JAN 1999 Parliamentary S

Minister for Health and Family Services 20 JAN 1999

20 JAN 1999

Signatory: Minister, Chief of Staff, Principal Adviser, Min Fam Serv, Parl Secretary
Department: Response, Approp Action, Phone Call, Information, Complaint

The Hon Dr Michael Wooldridge, MP
Minister for Health and Aged Care
Parliament House
CANBERRA ACT 2600

Dear Michael

I refer to the Prime Minister's letter to you of 22 December 1998 regarding the IT Outsourcing Initiative (the Initiative).

In his letter the Prime Minister reiterated general government policy that outsourcing of IT infrastructure services should proceed unless there is a compelling business case on a whole of government basis for not doing so. This is a policy of the Commonwealth for the purposes of Regulation 9 (a) of the Financial Management and Accountability Act 1997 Act (FMA Act) and applies to all budget funded agencies within your portfolio. Agency heads and boards will be accountable under the Commonwealth Authorities and Companies Act 1997 or the FMA Act or relevant agency specific legislation for their agency's full compliance with the requirements of the Initiative. Where necessary I may seek your cooperation in formally notifying this policy to CAC Act agencies and other agencies under relevant legislation.

The Prime Minister's letter mentioned that I had prepared a statement outlining the roles and responsibilities of agencies and the Office of Asset Sales and IT Outsourcing (OASITO) in implementing the Initiative. Consistent with the importance attaching to the early implementation of the Initiative, agencies will continue to have an important complementary role to play in service definition, technical evaluation and transition planning and execution, while OASITO will continue to take a key strategic and strong central management role to ensure the whole of Government objectives of the Initiative are met. This is reflected in the roles and responsibilities set out at Attachment A. These arrangements apply unless otherwise varied in any specific case.

I will continue to consult with you on IT Outsourcing decisions in your portfolio. Consistent with these arrangements I expect to consult with you in April/May on a preferred tenderer for the Health IT Outsourcing tender, which includes the Department of Health and Aged Care, the Health Insurance Commission and some requirements from Medibank Private. OASITO will continue to work with these organisations on this tendering process.

Parliament House CANBERRA ACT 2600 Telephone: (02) 6277 7400 Fax: (02) 6273 4110

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000114**

Topic: IT OUTSOURCING – COPIES OF LETTERS

Hansard Page: CA 118

Senator Lundy asked:

Copies of any letters/information received from OASITO or Minister for Finance etc re roles and responsibilities etc including any advice the Department may have sought re CAC act etc.

Answer:

Yes, a copy of the letter is attached to Question E01000113.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO .... Question: E01000115

Topic: IT OUTSOURCING – ANAO RULING

Hansard Page: CA 124

Senator Lundy asked:

ANAO ruling on status of Health equipment leases as part of the outsourcing arrangements.

Answer:

In conducting the 1999-2000 Financial Statement Audit, Closing Audit Report the ANAO advised the Department of Health and Aged Care that “We are satisfied with the Department’s treatment of the sale and lease back agreement”.

A copy of the letter is attached.

7 September 2000

Ms Mary Murnane
Chairperson Audit Committee
Department of Health and Aged Care
GPO Box 9848
Canberra ACT 2601

Dear Ms Murnane

1999-2000 FINANCIAL STATEMENT AUDIT
CLOSING AUDIT REPORT

Attached is our Closing Audit Report which summarises the results of our audit of the Department of Health and Aged Care 1999-2000 financial statements.

As indicated in the Report, the audit confirmed that the financial statements are fairly stated and presented. Accordingly an unqualified audit report will be issued upon receipt of the signed financial statements and management representation letter.

I would be pleased to discuss the report with you at the next Audit Committee meeting.

Yours sincerely

Gil Kensitt
A/g Executive Director

GPO Box 707 CANBERRA ACT 2601
Centenary House 19 National Circuit
BARTON ACT
Phone (02) 6203 7300 Fax (02) 6203 7777

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000116**

Topic: IT OUTSOURCING - TRAINING

Hansard Page: CA 125

Senator Lundy asked:

Information on how IT training is being managed in Health?

Answer:

IT end User Training for staff in Central Office is managed through a contract with Achieve Solutions. Achieve Solutions provides a full range of training in standard office software products and specialised corporate applications, including the Department's Document Management System. State and Territory Offices may also use the Achieve solutions contract for the provision of IT end user training, but retain the option of using other providers or delivering the training through in house resources.

Specialised training for IT professionals is arranged on a needs basis through a range of IT training 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

WHOLE OF PORTFOLIO **Question: E01000117**

Topic: IT OUTSOURCING - CONTRACT

Hansard Page: CA 125

Senator Lundy asked:

Copy of the Contract.

Answer:

An edited copy of the Department of Health and Aged Care's Services Agreement with IBM Global Services Australia has been forwarded to the Finance and Public Administration References Committee "Inquiry into the Governments information technology outsourcing initiative" by the Office of Asset Sales and IT Outsourcing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000118**

Topic: IT OUTSOURCING

Hansard Page: CA 125

Senator Lundy asked:

Copies of the evaluation reports as prepared by the Evaluation and Steering committees and also the one prepared by the Options Committee.

Answer:

The Department of Health and Aged Care has been advised by the Office of Asset Sales and IT Outsourcing that it is to provide an edited copy of the Evaluation Committee's report to the Finance and Public Administration References Committee "Inquiry into the Government's Information Technology Outsourcing Initiative".

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000173**

Topic: IT OUTSOURCING – HIC SERVICE AGREEMENTS

Hansard Page: CA120

Senator Lundy asked:

In relation to the notion of compensation for the removal from services of a major segment of HIC's business, can you give an example of what a major segment might be?

Answer:

The major segments described in the HIC's Services Agreement are:

- Mainframe services;
- Bulk document printing and dispatch services;
- Midrange services;
- Help Desk services; or
- Services that relate to 30% or more of Desktop systems

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000174**

Topic: IT OUTSOURCING – RESPONSE TIME

Hansard Page: CA 121

Senator Lundy asked:

(a) If the HIC had wanted additional response time would you have got it at a cheaper price had it not been outsourced, because you would have been able to access the government discount?

(b) What was the saving to government of the three-second response time service level if it had remained in-house?

(c) Does the interactive voice recognition system mean that people have to wait 15 seconds longer before a real person answers the phone?

(d) Can you tell me what, if any, trade-off there was in terms of costs or the ability to make perhaps greater savings as a result of making that difference or responding to that request from IBM-GSA to make that change?

Answers:

(a) The HIC retains the discounts offered to government agencies as it has retained its existing data telecommunications agreements with carriers. The HIC experiences no impact to services as IBM GSA is responsible for managing availability at HIC offices and for end-to-end response times across the network.

(b) There was no saving to government because the HIC retained its existing agreements with carriers, rather than accepting the service offered by IBM GSA at an additional cost of $3.1million.

(c) No. A caller can choose an option to speak to an operator at any time during the welcome message.

(d) The HIC believes that it didn't make a trade-off in terms of price. The extent of savings made is not known because the only Help Desk services offered were based on IVR (Interactive Voice Recording) technology. IVR technology allows multiple Help Desks to be accessed from a single telephone number, and provides an alert message broadcasting facility allowing callers to hear system status messages without having to wait for a human operator.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000175**

Topic: IT OUTSOURCING - MAINFRAME

Hansard Page: CA 125

Senator Lundy asked:

(a) Did IBM provide the mainframe prior to the contract being let?

(b) What proportion of the contract, either in percentage or even value terms, is going to maintaining the existing mainframe system?

Answer:

(a) IBM Australia provided the mainframe computer equipment to the HIC prior to the contract being let.

(b) The HIC purchases a service from IBM GSA that includes the provision of a fully maintained mainframe infrastructure on which HIC applications can be processed. While the service includes a charge for software licence administration, the HIC retains the software licences in its own name and pays licence fees directly to the licensor. Approximately 27% of service charges are paid for mainframe services consumption, which is within budget expectations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000262**

Topic: PROVISION OF MARKET RESEARCH REPORTS – PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Evans asked:

(a) Provide a copy of the revisited guidelines.

(b) Could the Department please provide copies of the reports on the 30% rebate advertising campaign and the Lifetime Health Cover advertising campaign, the release of which have been repeatedly deferred on the grounds that to do so would be premature. If these reports are not to be provided then can the Department say why it has decided not to provide the reports.

(i) Budget Estimates 1998/1999, Feb 8th 1999 - Q231
(ii) Budget Estimates 1999/2000, June 1st 1999 - Q272
(iii) Additional Estimates 1999/2000, Feb 7th 2000 -Q190
(iv) Supplementary Additional Estimates 1999/2000, May 2nd 2000 - Q137, Q138, Q139
(v) Budget Estimates 1999/2000, May 23rd 2000 - Q26, Q27

Answer:

(a) The revised guidelines are still under review and will be provided as soon as that review is complete.

(b) As indicated at the Hearing it is not appropriate to release the reports as they are being used in ongoing program development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000262 (a)**

Topic: PROVISION OF MARKET RESEARCH REPORTS – PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Evans asked:

(a) Provide a copy of the revisited guidelines.

(b) Could the Department please provide copies of the reports on the 30% rebate advertising campaign and the Lifetime Health Cover advertising campaign, the release of which have been repeatedly deferred on the grounds that to do so would be premature. If these reports are not to be provided then can the Department say why it has decided not to provide the reports.

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(iv) Supplementary Additional Estimates 1999/2000, May 2nd 2000 - Q137, Q138, Q139

(v) Budget Estimates 1999/2000, May 23rd 2000 - Q26, Q27

Answer:

Further to the earlier response to this question, please find attached the revised guidelines.

PRINCIPLES FOR THE CONDUCT OF SOCIAL RESEARCH

- The conduct of any research must support the objectives of Departmental programs, including the development and implementation of new initiatives.

- The Departmental Management Committee (DMC), comprising the Executive and Division Heads, will review the forward program of research activity from time to time to ensure its relevance, value and relative priority in terms of overall Departmental objectives as outlined in the corporate plan. DMC will also consider any resource implications particularly where the proposed research goes across a number of program areas.

- Research will be conducted in line with the Office of Government Information and Advertising (OGIA) guidelines particularly in relation to selection processes for, and conduct of, any consultancies involving public relations and communications aspects.

- The processes for managing market research (e.g. authorisation, cost, tender arrangements) are open to scrutiny by the Parliament and details must be provided if requested.

- Consistent with Freedom of Information (FOI) requirements the results of research may also be made available (though not where the research is an input to policy advice from the Department)

- Where the release of findings might jeopardise the achievement of program objectives or the smooth implementation of an initiative, release may be delayed or withheld consistent with FOI principles

- The decision on whether to release the results of research requires the agreement of the parties who were involved in the decision to commission the research and, in particular, the agreement of the Minister.

- In the event that the release of the detailed research findings is delayed or withheld consistent with these principles, consideration may be given to releasing a short report on the research, subject to the report not jeopardising the achievement of program objectives or the implementation of relevant initiatives

- All requests for research will be referred to Public Affairs, Parliamentary and Access Branch, which will maintain a database of requests.

23 May 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

WHOLE OF PORTFOLIO **Question: E01000221**

Topic: REPORTS ON ADVERTISING AND POLLING

Written Question on Notice

Senator Evans asked:

When will I receive a final copy on release of polling and advertising documents?

Answer:

Refer to answer E01000262

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000222**

Topic: ACTING POSITIONS

Written Question on Notice

Senator Evans asked:

How many senior management positions have been filled on an acting basis over the period going back to 1 July 1999 and for what lengths of time were each of those acting arrangements made?

Answer:

Senior management positions within the Department of Health and Aged Care comprise Senior Executive Levels 1,2 and 3, Medical Officer Levels 5 and 6 and Senior Principal Research Scientists. Of the 108 senior management positions in the Department, 77 were filled by acting arrangements during the period 1 July 1999 to 19 February 2001. This period encompasses a total of 428 working days.

The attached spreadsheet outlines the levels and total working days higher duties was performed for the relevant position. The higher duties periods on this spreadsheet may be aggregated.

CLASSIFICATION		POSITION NUMBER	TOTAL DAYS FILLED BY ACTING
SECRETARY		1	50
	Total	**1**	**50**
SEB 3		2	50
SEB 3		3	42
	Total	***2***	***92***
SEB 2		2560	10
		2429	45
		2552	64
		2525	115
		643	85
		2467	56
		337	40
		2540	59
		2553	156
	Total	***9***	***630***
SEB1		607	25
		2569	52
		11233	23
		8622	15
		7627	215
		2874	25
		10000	246
		231	113
		2556	161
		2426	105
		2559	155
		620	129
		1272	20
		3794	22
		2551	21
		5134	81
		937	29
		8231	40
		1592	33
		1350	22
		11231	15
		2515	111
		2508	301
		187	20
		4753	278
		466	289
		3646	67
		2498	130
		2874	117

		5421	35
		2533	52
		1447	148
		7868	56
		7576	289
		1299	31
		2760	32
		231	5
		5615	415
		6695	114
		1593	136
		8665	49
		9114	285
		2476	28
		162	131
		1350	79
		953	19
		2529	87
		7851	370
		5541	52
		2450	129
		1345	38
		2559	430
		96	233
		2438	97
		2458	212
	Total	***55***	***6412***
MO6		281	226
		5508	10
	Total	**2**	**236**
MO5		5346	52
		2890	96
		2483	149
		3314	42
		2497	10
		3422	92
		675	107
	Total	**7**	***548***
SENIOR PRINCIPAL RESEARCH SCIENTIST		4487	55
	Total	**1**	**55**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000210**

Topic: MINISTERIAL EXPENDITURE

Written Question on Notice

Senator Evans asked:

Can you provide full details of spending on Ministerial travel, conferences and entertainment for:

- **1999/2000**
- **1 July to 31 December 2000**

Answer:

Travel

During 1999/00 the Department spent the following on Ministerial travel:

Dr. Wooldridge			
Comcar	$11,937.91		
Private Car Hire	$85,580.00	Total	$97,517.91

Minister Bishop			
Comcar	$33,483.81		
Dasfleet	$9,795.44		
Private Car Hire	$17,852.11	Total	$61,131.36

Senator Tambling			
Comcar	$7,065.80		
Dasfleet	$12,318.32		
Private Car Hire	$1,343.06	Total	$20,727.18

During the period 1 July 2000 to 31 December 2000 the Department spent the following on Ministerial travel:

Dr. Wooldridge			
Comcar	$4,308.58		
Private Car Hire	$46,960.00	Total	$51,268.58

Minister Bishop			
Dasfleet	$894.94		
Comcar	$2,417.41		
Private Car Hire	$11,473.91	Total	$14,786.26

Senator Tambling

Comcar	$7,027.65		
Dasfleet	$5,372.31		
Private Car Hire	$691.20	Total	$13,091.16

Conferences

During 1999/00, and the period 1 July to 31 December 2000, the Department spent the following on conferences for Ministers:

1999/00	Nil
1 July to 31 December 2000	Nil

Entertainment

During 1999/00 the Department spent the following on entertainment costs for Ministers. These costs reflect functions which have been charged to the hospitality allocation within the Ministers' departmental budget.

Dr. Wooldridge	$12,398.34		
Minister Bishop	$1,359.85		
Senator Tambling	$0.00	Total	$13,758.19

During the period 1 July-31 December 2000 the Department spent the following on entertainment costs for Ministers.

Dr. Wooldridge	$9,936.90		
Minister Bishop	$1,437.41		
Senator Tambling	$0.00	Total	$11,374.31

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO .... Question: E01000211

Topic: MARKET RESEARCH

Written Question on Notice

Senator Evans asked:

(a) What market research and opinion polling has the Department conducted in 2000 and what polling does it propose to undertake in 2001?

(b) In each case, will the results of these polls be publicly released and if so when?

Answer:

(a) The Department of Health and Aged Care does not undertake opinion polling.

The following market research has been recorded.

Therapeutic Goods Administration (TGA)

The TGA has not conducted any market research in 2000.

In 2001 the TGA proposes to undertake two market research projects. These are:

- a survey of the readership of the Australian Adverse Drug Reactions Bulletin.
- a survey of the public in relation to tamper evident packaging.

Health Access and Financing Division (HAFD)

- In April 2000 research was undertaken to focus test two brochures designed to provide information on the Enhanced Primary Care (EPC) Medicare items to consumers and to allied health providers.
- In June 2000, providers and consumers were surveyed to gather information on early experience with the EPC items as part of a post-implementation review.
- A brochure providing information for general practitioners on the general practice Memorandum of Understanding was focus tested in December 2000.
- In August 2000 the Better Medication Management System (BMMS) Implementation Taskforce commissioned a qualitative research study examining concerns and information needs in relation to the BMMS.

- A study was undertaken over June and July 2000 into a title for BMMS to best demonstrate the benefits of the new system.
- In October 2000 qualitative market research was undertaken with consumers, doctors and pharmacists on a title for the Better Medication Management System (BMMS) and further research will be undertaken in 2001.
- Market research is planned for March to July 2001 as part of the Improved Monitoring of Entitlements (IME) to the Pharmaceutical Benefits Scheme (PBS) Communication Strategy. This research will include Developmental Research, Concept Testing, and Benchmark and Tracking Research to inform the development of the IME communication strategy, assess advertising concepts and gauge overall effectiveness of the communication strategy.

Health Services Division (HSD)

In June 2000 the Blood and Organ Donation Taskforce of the Department of Health and Aged Care commissioned a survey of 10 representative sample groups of blood donors and non-donors in NSW and WA regarding their knowledge of the Australian blood supply. Market research for 2001 is yet to be decided.

The After Hours Primary Medical Care Consumer Preference Study commenced in October 2000 and is expected to be completed by July 2001.

During 2000, market research commenced to examine consumers' perceptions of the effectiveness of the primary and community health care system, and to inform strategies to improve the responsiveness of the system to the needs of individuals with chronic health conditions. This research is continuing during 2001.

Qualitative Research of a Rural Health Newsletter and Website - completed in 2000 and used for internal purposes only. Research for 2001 is yet to be decided.

Qualitative Research for promotional materials for the Commonwealth's Rural Budget Initiative - Regional Health Strategy - More Doctors, Better Services - completed in 2000 and used for internal purposes only. Research for 2001 is yet to be decided.

Medical Practice and Corporatisation

Research on consumer awareness and perceptions of Medical Practice Corporatisation was conducted on behalf of the Department in 2000

Health Insurance Investment Division (HIID)

The Department undertook qualitative and quantitative market research to inform the Lifetime Health Cover Communications program. Research is continuing in 2001 to inform the extension of the campaign which focuses on recent changes around insurance ‘gaps’.

Insurance Policy Section

A survey was conducted in January and February 2001 of health fund members who had been hospitalised in recent times, asking them questions about informed financial consent.

Aged and Community Care Division (ACCD)

Accountability and Quality Assurance Branch

In 2000, a combination of qualitative and quantitative research was conducted on the type, style and content of information products required by aged and community care consumers, potential consumers and service providers.
No further research is planned for 2001.

National Health and Medical Research Council (NHMRC)

The National Health and Medical Research Council (NHMRC) did not conduct any market research in 2000. The NHMRC has agreed to undertake market research into proposed new logos, alternate branding and positioning statements for the NHMRC in early 2001. This is part of the implementation of a new Communications Strategy for the NHMRC.

Portfolio Strategies Division (PSD)

It is anticipated that a large quantitative survey, testing the performance of those programs that are the Department's responsibilities, will be conducted late in 2001.

Population Health Division (PHD)

Immunisation and Vaccine Preventable Diseases Section:

- a national CATI (computer assisted telephone interviewing) survey was conducted in August 2000 to provide national and state/territory influenza coverage estimates for adults (65+ years) and to address other adult vaccine-related issues; and
- qualitative research into attitudes to immunisation

Drug Strategy and Population Health Social Marketing Branch:

Market research commissioned since January 2000

PROJECT	PURPOSE
BreastScreen Australia Program	Identify issues for non-attenders
Immunisation Australia Program	Concept testing of handbook with parents of 0-6 years
National Youth Alcohol Campaign	Process evaluation with parents of 13-17 year olds
National Tobacco Campaign	Concept testing with smokers aged 16-40 years
National Youth Alcohol Campaign	Process evaluation with youth aged 14-17 years
National Illicit Drugs Campaign	Concept testing with parents of 8-17 years and youth 12-17yrs (Phase 2)
BreastScreen Australia Program	Development research to inform upon the recruitment and retainment of radiographers
National Illicit Drugs Campaign	Concept testing with parents of 8-17 years and youth aged 12-17 years (Phase 3)
National Tobacco Campaign	Continuous information tracking for Campaign

Cigarette Ingredients and Emissions	Knowledge and attitude towards information on cigarette ingredients & emissions
National Youth Alcohol Campaign	Evaluation research with youth (15-17 years) and parents of 12-17 years
National Youth Alcohol Campaign	On-line survey with stakeholders
Environmental Tobacco Smoke	Review to inform the development of an Education Strategy for ETS
National Illicit Drugs Campaign	Concept testing with parents 8-17 yrs (Phase 4 & 5)
National Illicit Drugs Campaign	Benchmark research with parents of 8-17 year olds and community 18+ years
Croc Eisteddfod – Weipa	Evaluation of Sponsorship
Falls Prevention Communication Research	Developmental research to inform the development of an information and liaison strategy for the National Falls Prevention for Older People Initiative
North's 2000 3-On-3 Basketball Challenge	Evaluation of Sponsorship
National Illicit Drugs Campaign	Concept testing with parents of 8-17 year olds (Phase 6)
National Youth Alcohol Campaign	Concept testing of revised materials for Wave two of campaign
BreastScreen Australia Program	Benchmark research with women 40-69 years
National Illicit Drugs Campaign	Concept testing with parents of 8-17 year olds (Phase 7)
Standard Drinks Research	Awareness and knowledge of the concept of a standard drink
National Tobacco Campaign	Nov 2000 evaluation of National Tobacco Campaign
Ingredients and Emissions	Evaluation of Ingredient's information on the Depts website
Rock Eisteddfod	Evaluation of the National Alcohol Campaign Sponsorship of the 2000 REC
National Illicit Drugs Campaign	Concept testing with parents of 8-17 years and youth aged 15-17 years (Phase 8)
National Youth Alcohol Campaign	Evaluation research with youth 15-17 years (Wave 2)
National Youth Alcohol Campaign	Omnibus survey with parents of 15-16 year olds (Wave 2)
Behavioural Risk Factor Framework (SNAP)	Research with GPs in to the Behavioural Risk Factor Framework

Market Research planned for 2001 covers the following issues:

- National Illicit Drugs Campaign
- National Tobacco Campaign
- Health warnings on cigarette packaging
- BreastScreen Australia Program
- Immunisation
- Rock Eisteddfod Challenge
- Alcohol advertising
- Alcohol drinking patterns

(b) Release of the results of market research will be in line with the Department's guidelines.

Decisions have so far been taken to release:

- Preliminary report on National Youth Alcohol Campaign (released Nov 2000).
- The results of the national CATI Influenza and Pneumococcal Survey (to be released by the end of April 2001)
- Evaluation report V3 on National Tobacco Campaign (to be released late 2001).
- Preliminary Report on Environmental Tobacco Smoke (to be released June 2001).
- National Illicit Drugs Campaign (to be released as part of Evaluation report late 2001).
- Falls Prevention Communication Research (to be released in April 2001).
- BreastScreen Australia Program (to be released as part of Evaluation report late 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

WHOLE OF PORTFOLIO ....Question: E01000212

Topic: TV AND RADIO ADVERTISING

Written Question on Notice

Senator Evans asked:

(a) How much has the Department spent on television and radio advertising in 2000 and what advertising does it propose to undertake in 2001?

(b) What is the subject matter for each major campaign proposed and where will the funds be drawn from?

Answer:

(a) and (b)

The Department spent $14.9 million on television and radio advertising in 2000.

A number of activities are planned for 2001 across a range of portfolio Outcomes from 1 through 9. Funding for advertising campaigns is allocated as part of the portfolio budget.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO ....Question: E01000213

Topic: APPROVAL OF TV ADVERTISING

Written Question on Notice

Senator Evans asked:

What role has the Minister played in the initiation and approval of each TV advertising campaign?

Answer:

All TV advertising campaigns undertaken by the Department are developed with the approval of the Minister/s and cleared by the Ministerial Committee on Government Communication (MCGC) of which the Minister/s is/are a member/s.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO ....Question: E010000214

Topic: APPROVAL OF ADVERTISING

Written Question on Notice

Senator Evans asked:

(a) On how many occasions in 2000 did the Department present advertising proposals to the Cabinet Subcommittee on Government Advertising?

(b) In how many of these cases was the proposed advertising amended following comments by the Committee? What was the additional cost of these changes?

Answer:

(a) In 2000, the Department presented advertising/advertising related proposals to the Ministerial Committee on Government Communication (MCGC) in-meeting session on 12 occasions and out-of-session on 14 occasions.

(b) All advertising proposals presented by the Department to MCGC were amended at various stages of development in line with Committee considerations. Costs were in line with forecast Budgets.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO .... Question: E01000215

Topic: INFORMATION MAIL OUTS

Written Question on Notice

Senator Evans asked:

(a) On how many occasions in 2000 did the Department undertake large scale information mail-outs to the public or groups with interests covered by the Department?

(b) What were the numbers of letters sent in each case and what was the total cost of the printing, preparation and mailing of these letters?

Answer:

(a) Therapeutic Goods Administration (TGA) And Interim Office Of Gene Technology Regulator (IOGTR) = 17

Health Services Division (HSD) = 1

Health Access and Financing Division (HAFD) = 3

Aged and Community Care Division (ACCD) = 16

Population Health Division (PHD) = 6

National Health And Medical Research Council (NHMRC) = 1

(b) **TGA**

1. The *Prescribing Medicines in Pregnancy* booklet (50,224 copies) that was sent out with an issue of the Australian Prescriber magazine. Total cost calculated as $22,806.94.
2. Two mail-outs (200 letters in total) for consultation of the draft *Guidelines for Levels and Kinds of Evidence to Support Claims for Therapeutic Goods.* Total cost calculated as $90.00*
3. Three mail-outs (640 letters in total) on the redevelopment of the Electronic Lodgement Facility for applications of listed medicines. Total cost calculated as $1018*.
4. Two mail-outs (600 letters in total) on the review of Therapeutic Goods Advertising Code. Total cost calculated as $180*.
5. One mail-out (1,245 letters) on consultations for the registration of Class I medical devices. Total cost calculated as $960.

6. Five mail-outs (2804 letters in total) on consultations for various changes to medical device legislation including the introduction of specific Therapeutic Goods Orders. Total cost calculated as $1261*.
   *postage costs only for these internally produced documents

IOGTR

1. The following were posted to approximately 3000 recipients at an estimated cost of $35,057:
   - Draft Gene Technology Bill, 2000,
   - Draft Gene Technology Bill 2000 Explanatory Memorandum
   - Draft Gene Technology (Consequential Amendments) Bill 2000
   - Draft Gene Technology (Licence Charges) Bill 2000
   - Draft Gene Technology (Licence Charges) Bill 2000 Explanatory Memorandum
   - Draft Gene Technology (Consequential Amendments) Bill 2000 Explanatory Memorandum
2. The following was posted to approximately 3000 recipients at an estimated cost of $19,591:
   - Explanatory Guide to the Gene Technology Bill, 2000
3. The following was posted to approximately 3000 recipients at an estimated cost of $31,355:
   - Gene Technology Regulations 2000 and Explanatory Guide to the Gene Technology Regulations 2000.

In total the estimated cost of Preparation, Printing and Mailout on all occasions was $86,003.

HSD

A total of 590,000 letters at the cost of $346,369. A total of 35,000 letters at a cost of $25,000 (although separate costs, considered one combined mail-out)

HAFD

In October 2000 the Department undertook a bulk mail-out to individual medical practitioners of a ready-reckoner for corrections to the maximum patient gap in the Medicare Benefits Schedule. 34,402 letters were sent in the mail-out and the total cost of printing, preparation and mailing of the letters was $39,131.13.

The brochure "Be Wise with Medicines....the facts" was distributed in March 2000 via a minor mail out to community groups with an interest in the quality use of medicines. Large quantities of the brochures were subsequently supplied to peak organisations that undertook to distribute the brochures free of charge to the public or other interested groups. The total cost of printing the brochures was approximately $100,000. The minor distribution of the brochures was approximately $2,000. The brochure is still being distributed to interested members of the public and other groups when requested.

In December 2000 Improved Monitoring of PBS Entitlements (IME) Information Kits and Brochures were sent out. 5,000 kits containing information about the IME measure, including brochure, poster and counter card were sent to pharmacists. 1,000,000 IME brochures were printed with 660,000 have been distributed to date through pharmacies, Medicare offices and free call 1800 information line. The total cost was $77,431.

ACCD

Accountability and Quality Assurance Branch

Topic	Total Number Distributed	No. Distributed by Fax	No. Distributed by Mail	Printing, Preparation & Distribution Costs*
Information relating to the GST and aged and community care services	4,362	0	4,362	$8,901.40
Complaints Resolution Scheme information dissemination	24,493	0	24,493	$22,341.00
Information kit relating to the Minister's Awards for Excellence in Residential Aged Care	3,472	0	3,472	$46,626.36
Distribution of the draft *Aged Care Sector Code Of Conduct And Ethical Practice* for comment	5,361	0	5,361	$12,163.16
Information relating to the sale, transfer or relocation of Residential Care Services	3,023	2,873	150	$4,492.80
Notification of increased funding rates in Aged Care Services	2,729	2,729	0	$8,576.00
Announcement of the creation of Minister's Awards for Excellence in Residential Aged Care	2,756	2,756	0	$2,164.80
Invitation to apply for the Minister's Awards for Excellence in Residential Aged Care	2,756	2,756	0	$2,138.40
Announcement of the Minister's Awards for Excellence in Residential Aged Care winners	2,721	2,721	0	$3,176.40
Information on the development of *Handling Customer Complaints – Turning Challenges into Opportunities*	2,544	2,544	0	$2,066.40
Encouragement of residential care services to submit full accreditation application by the 31 March 2000	2,759	2,759	0	$2,168.00
Information relating to the development of the Residential Aged Care Sanctions Website	2,541	2,502	39	$2,936.40

* this includes GST where applicable

CERTIFICATION AND APPROVED SERVICES SECTION, RPMG BRANCH

1. July 2000: mailout on 'fire safety and certification'
   See Aged and Community Care listing above
2. November 2000: 'certification and accredited services': 2,500 letters @ $864

PHD

Social Marketing

Campaign Title	No of Letters	Total Cost (Printing and Mailing)
National Tobacco Campaign	20,000	$15,165
National Alcohol Campaign	20,000 20,000	$9,289 $7,443
Immunise Australia Campaign	24,000 24,981	$435,402.83 (7th Edition of the Immunisation Handbook) $58,552.07
Total Number of Mailouts = 5		

HIV/AIDS & Hepatitis C Section

There was only one occasion where a mail-out was conducted with a print run larger than 5,000 copies. The Needle and Syringe Program Information Kit
Total Print Run: 23,500 copies
Total Cost: $88,000 (for printing & distribution)

NHMRC

20, 778 copies of the NHMRC News No. 4 were distributed to General Practitioners, medical researchers, consumers and other health professionals in August 2000 at a total cost including GST $43,522.37 ($3,095.21 GST).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

WHOLE OF PORTFOLIO **Question: E01000216**

Topic: GOVERNMENT MPs ON COMMITTEES

Written Question on Notice

Senator Evans asked:

Please provide a list of all Government MP's or Senators who are members of, or attend meetings of any Committee, task force, review or other group established by an agency within the portfolio spelling out when the MP or Senator was appointed and their role on the committee

Answer:

In responding to this question the Department has provided details of a committee, task force, review or other group that has been established by the portfolio (including the Department and its agencies). Details of committees, task force, reviews or other groups established not by the Department or its agencies but through a parliamentary process, have not been included.

- Mrs Kay Hull MP, Federal Member for the Riverina, has been a committee member of the Greater Murray Clinical School's Community Advisory Board Committee since June 1999. Mrs Hull’s role is that of a general committee member.

ATTACHMENT A

PRINCIPLES FOR THE CONDUCT OF SYSTEMATIC SOCIAL RESEARCH

- The conduct of any research must support the objectives of Departmental programs including the development and implementation of new initiatives.

- The Departmental Management Committee (DMC), comprising the Executive and Division Heads, will review the forward program of research activity from time to time to ensure its relevance, value and relative priority in terms of overall Departmental objectives as outlined in the corporate plan. DMC will also consider any resource implications particularly where the proposed research goes across a number of program areas.

- Research will be conducted in line with the Office of Government Information and Advertising (OGIA) guidelines particularly in relation to selection processes for, and conduct of, any consultancies involving public relations and communications aspects.

- Consistent with Freedom of Information (FOI) requirements the results of research generally can be expected to be made available in due course, either to the public on request or through selected distribution to libraries etc.

- Where the release of findings might jeopardise the achievement of program objectives or the smooth implementation of an initiative, release may be delayed or withheld consistent with FOI principles.

Final
June 1998

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 1: POPULATION HEALTH AND SAFETY ....Question: E1000126

Topic: ILLICIT DRUGS – HEROIN PRICE

Hansard Page: CA 8

Senator Denman asked:

Could you find out for me whether the heroin price also increased during this period [of scarcity of street heroin in Melbourne and Sydney during the early part of this year]?

Answer:

Anecdotal reports indicate that the price of heroin has increased in Melbourne and Sydney during the early part of this year.

Melbourne

	Pre Christmas	February 2001
1Cap	$20	$50
1Gram	$400	$1000

Sydney (Cabramatta)

	Pre Christmas	February 2001
1 Cap	$20	$50
1 Gram	$270	$400

Source: Anecdotal evidence from NSW Police and Victorian Police Drug and Alcohol Coordinators and the Australian Bureau of Criminal Intelligence.

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 1: POPULATION HEALTH AND SAFETY **Question: E1000127**

Topic: ILLICIT DRUGS – NALTREXONE IMPLANTS

Hansard Page: CA 8

Senator Denman asked:

Is any research being conducted in Australia into naltrexone implants amongst heroin injectors?

Answer:

The Department of Health and Aged Care is not aware of any research, in the context of clinical trials of naltrexone implants, currently being conducted in Australia. The Department understands, however, that several practitioners are utilising these implants to treat opioid dependent people under special provisions of the Therapeutic Goods Act which allow patients to obtain limited access to unregistered medicines.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000128**

Topic: ILLICIT DRUG DIVERSION INITIATIVE

Hansard Page: CA 10

Senator Gibbs asked:

How many states and territories have implemented programs under the supporting measures package of the COAG agreement on illicit drugs of April 1999?

Answer:

Supporting measures being implemented by States and Territories are as follows:

Diversification of Needle and Syringe Program
All States and Territories are implementing the Supporting Measures Relating to Needle and Syringe Programs.

Family Support Measures
Four states and one territory are in the process of implementing projects under the Family and Youth Support measures package of the COAG agreement on illicit drugs. They are the Australian Capital Territory, Western Australia, Victoria, South Australia and Tasmania. The Department of Family and Community Services is currently finalising the Memorandum of Understanding for the Northern Territory, Queensland and New South Wales.

School Drug Education
Government and non-government State/Territory school jurisdictions submitted a collaborative cross-sectoral State/Territory proposal for funding for local school community drug summits.

Funding for the summits has been approved and contracts have been signed with all States and Territories apart from the Northern Territory and Victoria, which are under negotiation and expected to be signed shortly. The summits are expected to commence early in the 2001 school year and be delivered over the following three years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19 February 2001

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E01000129**

Topic: METHADONE PROGRAM – FIGURES 1997 ONWARDS

Hansard Page: CA 12-13

Senator Evans asked:

(a) **Could someone give me the figures [for the methadone program] for each budget from 1997 onwards?**

(b) **What has happened each year to the $13 million [methadone program funding]? Has that gone back into the drug strategy or is it carried over?**

(c) **[Has the diversion of money to other programs] resulted in a net increase in those moneys available to those programs or not?**

(d) **Could you give me a breakdown of where that $13 million has been allocated and to what programs? Could you do that from 1997 onwards?**

Answer:

(a) Below is a table of budget allocations for restructure arrangements for funding services related to the provision of methadone (as listed in the 1997/98 Portfolio Budget Statements) from 1997/98 to the current financial year.

1997-98 $m	1998-99 $m	1999-00 $m	2000-01 $m
0.0	10.2*	18.2*	21.4

* The 1998-99 and 1999-00 budgets were reduced by approximately $1.2m and $4.2m respectively during the 1998/99 Additional Estimates process. This reduction occurred as a result of delays in the implementation of the program, due to complexity of negotiations with state and territory Governments regarding implementation of trials.

(b) There were no funds allocated to restructure arrangements for funding services related to the provision of methadone in 1997/98. In 1998/99 $141,000 was spent on the program. The remaining funds subsequently lapsed. In 1999/00 $10,000 was spent. The remaining 1999/00 funds ($13.987m) were unspent and rephased to 2000/01.

(c) There was a net increase in Outcome 1 funding in 2000-01 of $13.987m.

(d) None of the funds allocated for restructure arrangements for funding services related to the provision of methadone in 1997/98, 1998/99 and 1999/00 were spent on other programs. However, a decision was made to rephase the unspent 1999/00 funds to 2000/01

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 1: POPULATION HEALTH AND SAFETY **Question: E01000130**

Topic: METHADONE PROGRAM

Hansard Page: CA 14

Senator Evans asked:

Can you explain to me what else the Commonwealth spends on Methadone – how else you fund it?

Answer:

The Commonwealth funds Methadone through the following three areas:

1. Methadone services are funded under the Medicare Benefits Scheme (MBS). Some expenditure data will be available from a Commonwealth commissioned National Drug and Alcohol Research Centre (NDARC) Health Care Utilisation Study in the near future.

2. Funding is provided to States/Territories through the Public Health Outcome Funding Agreement (PHOFA) for public health services including methadone clinics.

3. The cost of methadone syrup is funded under Section 100 of the Pharmaceutical Benefits Scheme (PBS). In 1999/00 $3.959 million was spent on methadone.

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 1: POPULATION HEALTH AND SAFETY .... Question: E01000131

Topic: METHADONE PROGRAM – PBS FIGURE

Hansard Page: CA 15

Senator Evans asked:

(e) Do you know what the PBS figure (for expenditure on methadone) is?

(f) Is it fair to assume that there have been no savings on the Medicare program because the (methadone program) measure has not gone ahead.

Answer:

(e) In 1999/00 Commonwealth expenditure on methadone was $3.959 million under the Pharmaceutical Benefits Scheme (PBS).

(f) 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 1: POPULATION HEALTH AND SAFETY **Question: E01000132**

Topic: SEXUAL HEALTH REFERENCE GROUP

Hansard Page: CA 25, 38 & 39

Senator Harradine asked:

(a) [Who are the] members of the Sexual Health Reference Group and the National Strategies Coordination Working Group?

(b) Does the membership of the Sexual Health Reference Group include representatives of a wide range of community and professional groups?

(c) I would like to know how much this Sexual Health Reference Group has cost thus far, including the consultant's fee?

(d) Would you provide the committee with a copy of that advice and those recommendations [of the Sexual Health Reference Group to the National Population Health Partnership meeting in February]?

Answer:

(a) Attached is a list of the members of the Sexual Health Reference Group (SHRG) and the National Strategies Coordination Working Group (NSCWG) (at Attachment A). The SHRG was dissolved in September 2000. The NSCWG oversees the National Public Health Partnership's work program regarding the improved coordination of national public health strategies.

(b) The list provided at Attachment A indicates the professional status of the members of the Sexual Health Reference Group and/or the organisations the members represent. The SHRG was a time-limited group with public health and sexual health technical expertise formed to advise the Commonwealth on the need for and possible scope of a national sexual health strategy. The members were drawn from relevant areas of the Commonwealth and State and Territory health departments, the National Public Health Partnership, specialist centres in sexual health research and practice, and currently funded programs.

(c) The total costs for the SHRG were $16,382. The total amount paid to McCallum and Young Consultants was $52,500.

(d) In August 2000, the SHRG referred the consultant's draft final report to the NSCWG for their consideration. The NSCWG's initial discussions by teleconference led to advice to the National Public Health Partnership at its August 2000 meeting that the NSCWG would meet face-to-face to develop more detailed responses to the final report and make recommendations to the NPHP at its November 2000 meeting.

However, the NSCWG has not been able to meet to consider this issue. Its next meeting will be held on 11 April 2001, at which it will examine the consultant's report in more detail. It is expected that the NSCWG will make recommendations to the NPHP for consideration at its next meeting in June 2001.

Question:E01000132 **ATTACHMENT A**

MEMBERSHIP OF THE SEXUAL HEALTH REFERENCE GROUP

(as at August 2000)

CHAIR

Dr Cathy Mead	Department of Health and Aged Care

MEMBERS

Dr Shirley Bowen	National Public Health Partnership, and Chief Medical Officer, ACT Health
Professor Lenore Manderson	Key Centre for Women's Health, University of Melbourne
Ms Judi St Clair	Family Planning Association, Western Australia
Professor David de Kretser	Director, Institute of Reproduction and Development, Monash University
Ms Sera Pinwell	Scarlet Alliance
Mr Arnold Hunter	Chair, National Aboriginal Community Controlled Health Organisation
Ms Polly Sumner	National Aboriginal Community Controlled Health Organisation
Dr Sophie Couzos	Public Health Adviser, National Aboriginal Community Controlled Health Organisation
Dr Mark Wenitong	Physician, Men's Health and Prisons Health, Wu Chopperen Health Service, Cairns
Mr Darryl O'Donnell	National President, Australian Federation of AIDS Organisations
Ms Vicki Fraser	Anti-Discrimination and Health Policy, NSW Department of Education
Mr Joseph O'Reilly	Chair, National Public Health Partnership Advisory Group
Dr Anna McNulty	Physician, Sydney Sexual Health Centre
Ms Debbie Pittam	Australian Sexual Health Nurses

Professor John Kaldor	Epidemiologist, National Centre in HIV Epidemiology and Clinical Research
Dr Elvira Bardon	Sexual Health and HIV/AIDS Physician
Dr David Bradford	Director, Special Health Services, Queensland Health
Dr Jan Savage	Coordinator, AIDS/STD Unit, Northern Territory Health Service
Associate Professor Gary Dowsett	Australian Centre in Sex, Health and Society

EX OFFICIO MEMBERS

Mr Paul Lehmann	Communicable Diseases and Environmental Health Branch, Population Health Division, Department of Health and Aged Care
Dr Angela Merianos	Communicable Diseases and Environmental Health Branch, Population Health Division, Department of Health and Aged Care
Ms Joy Russo	Primary Prevention and Early Detection Branch, Population Health Division, Department of Health and Aged Care

MEMBERSHIP OF THE NATIONAL STRATEGIES COORDINATION WORKING GROUP (as at 27 February 2001)

CHAIR

Dr Shirley Hendy	Chief Health Officer, Territory Health Services

MEMBERS

Ms Mercia Bresnehan	Department of Health and Human Services, Tasmania
Dr Margaret Scott	NSW Health
Professor Mark Elwood	Anti Cancer Council
Ms Michele Herriot	South Australian Department of Human Services
Ms Sophie Dwyer	Queensland Health
Professor Vivian Lin	Australian Institute of Health and Welfare

Mr MartinTurnbull	Victorian Department of Human Services
Mr Brian Corcoran	Commonwealth Department of Health and Aged Care
Ms Myree Rawsthorne	ACT Department of Health, Housing and Community Care
Mr Colin Sindall	Commonwealth Department of Health and Aged Care
WA is vacant	
Dr Cathy Mead	Executive Officer, National Public Health Partnership

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 1: POPULATION HEALTH AND SAFETY **Question: E01000133**

Topic: PUBLIC HEALTH OUTCOME FUNDING AGREEMENT

Hansard Page: CA 26, 27, 29

Senator Crowley asked:

(a) Would it be possible to provide me with a copy of the framework agreements [for Public Health Outcome Funding

(b) Could I have the last couple of years' data [of the Public Health Outcome Funding Agreement] from New South Wales?

Answer:

(a) The framework agreements for Public Health Outcome Funding are attached (Attachment A).

ACT	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/act.pdf
NSW	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/nsw.pdf
NT	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/nt.pdf
QLD	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/qld.pdf
SA	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/sa.pdf
TAS	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/tas.pdf
VIC	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/vic.pdf
WA	http://www.health.gov.au/pubhlth/about/phofa2000/pdf/wa.pdf

[Note: The Agreements have not been included in the printed volume]

(b) The following documents are attached (Attachment B):

(1) 1998/1999 NSW State Government Report.

http://www.health.gov.au/pubhlth/about/phofa2000/pdf/nsw_rep98-99.pdf

(2) 1998/1999 National Consolidated Report.

http://www.health.gov.au/pubhlth/about/phofa2000/report.pdf

[Note: The consolidated report has not been included in the printed volume]

(3) Indicative Timetable of performance reporting against the PHOFAs for 1999/2000 (designed to provide an approximate timeframe for the examination and finalisation of the draft PHOFA Reports and preparation of the National Consolidated Report).

(4) The 1999/2000 NSW PHOFA Report is in the draft stages and currently undergoing a series of checks and edits. Therefore only the segment of this report pertaining to the Alternative Birthing Services Program is enclosed. This segment elaborates on the alternative birthing services provided in NSW and outlines the fact that the PHOFA funding for the Alternative Birthing Services Program in NSW is currently utilised solely for Indigenous women.

INDICATIVE TIMETABLE FOR PERFORMANCE REPORTING AGINST PHOFAS 1999/2000

ACTION	DATE
New and agreed report proforma circulated to State and Territory Health authorities.	First week in Oct 2000
Draft PHOFA report requested from State and Territory Health authorities using new proforma.	Due date last week in Oct 2000
Draft reports received: ACT NSW NT QLD SA VIC TAS WA	 13 Nov 2000 9 Jan 2001 3 Nov 2000 24 Oct 2000 21 Nov 2000 6 Nov 2000 10 Nov 2000 Not received (at 3 March 2001)
Checking/editing of each Draft report: • Reports forwarded to program areas in the DHAC for their comments. • Comments received from program areas. • Draft reports/comments forwarded to DHAC State and Territory offices for comment. • State and Territory Health authorities finalise PHOFA reports.	 • Nov 2000 • Feb 2001 (extensions given due to Christmas leave). • Early March 2001 – allowing approximately two weeks for their comments. • Mid March 2001 allowing approximately two weeks for finalisation of draft reports.
Final State and Territory PHOFA reports placed on website.	April 2001
Draft national consolidated report prepared by DHAC.	April 2001
Final national consolidated report placed on the website.	May 2001

The 2000-01 reports are expected to be more efficiently finalised as the proforma has been agreed and tested. The intention is to have the reports available by December 2001.

Extract from Draft NSW Report 1999-2000

Alternative Birthing Services Program

Performance indicator	Target / Reporting Requirement	1999/2000 report
3. Health departments encourage midwife based birthing services to be established in the publicly funded health care system and for Indigenous women.	Report, which lists and briefly describes services and models operating under the program.	ABSP funds the following services annually: Employment of Aboriginal Workers and midwives at four Aboriginal Medical Services: Walgett AMS Durri AMS Illawarra AMS Tharawal AMS To provide outreach antenatal and postnatal care for Aboriginal women. Partnership project between Hunter Area Health Service and Awabakal AMS for two years 98/99-99/00 for Midwife and Community based Aboriginal Health Worker.
		1998/99 -1999/00 one-off funded projects now complete: • Midwife exchange program. Training of midwives at Royal North Shore Hospital from Wilcannia and Walgett. • Maternal Care Workbook for Aboriginal workers and community - Illawarra Area Health Service • New England Area Health Service Community Based Midwife and Aboriginal Health Worker Macquarie Area Health Service Community Midwife and Aboriginal Education Officer
		All Area Health Service projects implemented under a model of partnership between Area Health Services and Aboriginal Community Medical 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 1: POPULATION HEALTH AND SAFETY **Question: E01000134**

Topic: NATIONAL PUBLIC HEALTH PARTNERSHIP MEMBERSHIP

Written Question on Notice

Senator Harradine asked: CA39

The report has been referred to the National Public Health Partnership for consideration and further action. Who are they?

Answer:

The members of the National Public Health Partnership are:

- Dr Andrew Wilson (Chair)
  Chief Health Officer
  Deputy Director General
  Public Health
  NSW Health Department
- Dr Paul Dugdale
  Acting Chief Health Officer
  Executive Director
  Population Health Group
  ACT Department of Health, Housing and Community Care
- Professor John Catford
  Director
  Public Health and Development Division
  VIC Department of Human Services
- Dr Rowan Davidson
  Acting General Manager
  Public Health Services
  Health Department of WA
- Mr Philip Fagan-Schmidt
  Director
  Policy Strategic Planning and Policy Division
  SA Department of Human Services
- Dr Mark Jacobs
  Director
  Environmental and Public Health
  TAS Department of Community and Health Services

- Dr Shirley Hendy
  Chief Health Officer
  Assistant Secretary
  Public Health Services
  Territory Health Services NT
- Mr Brian Corcoran
  First Assistant Secretary
  Population Health Division
  Commonwealth Department of Health and Aged Care
- Dr John Scott
  State Manager
  Public Health Services
  QLD Department of Health
- Professor Adele Green
  Chair
  Health Advisory Group
  National Health & Medical Research Council
- Dr Richard Madden
  Director
  Australian Institute of Health and Welfare
- Dr Helen Keleher (Observer)
  Chair, NPHP Advisory Group
- Dr Don Matheson (New Zealand Observer)
  Acting Director/General Manager, Public Health Group
  New Zealand Ministry of Health

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 1: POPULATION HEALTH AND SAFETY **Question: E01000149**

Topic: METHATREXATE FATALITIES

Hansard Page: CA 22

Senator Harradine asked:

Could you provide the Committee with what were the uses of methatrexate which involved a fatal outcome? What were they used for?

Answer:

The answer to this question has been provided as part of the response to (a) of Question: E01000102.

Case summary printouts for the above reports were also provided in response to E01000102

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 1: POPULATION HEALTH AND SAFETY **Question: E01000153**

Topic: GENE TECHNOLOGY

Hansard Page: CA 32,34

Senator Crowley asked:

(a) And how many sites does 11% represent? (relates to the IOGTR September Quarterly Report reporting monitoring of field sites)

(b) How many of those sites were Aventis sites?

(c) Could you also provide a list of all the companies or organisations who have sites?

(d) Of that 11% how many sites caused concern?

(e) Can you provide details of the investigation reports of sites that have caused concern, including name of the company and details of any action taken?

(f) How many breaches of GMAC guidelines has Aventis now made, including those in Mount Gambier?

(g) Could you provide us with the answer as to which other sponsors have breached GMAC and how many breaches have been made?

(h) Your September report states that the Interim Office was made aware of two other alleged breaches of GMAC guidelines during the reporting period. What were the breaches? (Note: response to be provided when breach investigations have been completed)

Answer:

(a) The IOGTR's monitoring program commits the Office to a monitoring target of 20% of current trial sites within 12 months (ie. 5% per quarter):

- In the July – September 2000 quarter, 24 current trial sites (21% of the total current trial sites for that quarter) were monitored;
- In the October – December 2000 quarter, 22 current trial sites (ie. 11% of the total current trial sites for that quarter) were monitored.

(b) Of the total 46 current trial sites monitored during the period July 2000 to December 2000, 24 were Aventis sites.

(c) A list of all the companies or organisations, and type of organism, which had current field trials as at the end of the last quarter (October-December) are set out below:

Organisation	**Type of organism**
Aventis	Canola/Indian mustard
Monsanto	Canola
Monsanto	Cotton
LaTrobe University	White clover
Qld University and BSES	Sugarcane
BSES	Sugarcane
CSIRO Tropical Agriculture	Sugarcane
Agriculture Western Australia	Cotton
Agriculture Western Australia	Pea
CSIRO Plant Industry	Cotton
CSIRO Plant Industry	Grapevine
CSIRO Plant Industry	Pea
CSIRO Plant Industry	Wheat
CSIRO Plant Industry	Barley
University of Qld	Pineapple
University of Qld	Papaya
Deltapine	Cotton
QLD Department of Primary Industry	Papaya
QLD Department of Primary Industry	Lettuce
QLD Department of Primary Industry	Pineapple
QLD Department of Primary Industry	Cotton
University of Western Australia (CLIMA)	Lentil
(CLIMA)	Peas
GlaxoSmithKline	Poppy

(d) Of the 11% of current trials monitored in the October to December 2000 period, one current site required remedial action as a result of non-compliance with GMAC recommendations. GMAC has advised that the risks were negligible.

(e) **PR77X(3)**: One of the thirteen Monsanto canola trials sites inspected required remedial action. A small number of wild radish plants (approximately six), a weedy relative of canola, had been found within the 50m exclusion zone. GMAC recommendations are that related weeds be removed from around the site to remove the potential for outcrossing from the transgenic plants to related plants. The weeds found appeared to have missed a spray application that had been applied to the area before flowering. A number of the plants had reached early seed development and the trial manager destroyed the plants before seeds became viable. As remedial action was taken the risk is considered negligible.

(f) Of the breaches reported in the IOGTR Quarterly Reports released to-date, Aventis have been involved in the following breaches:

- the incident at Mount Gambier as reported the June 2000 Quarterly Report
- past canola sites oversown to canola as detailed in the Audit of Aventis report
- the Audit of Aventis was triggered by a cumulative string of issues of concern rather than any specific breaches of GMAC guidelines
- three sites of concern as reported in the September 2000 Quarterly Report
- sites in Tasmania found to be non-compliant by IOGTR during routine monitoring and still under investigation

(g) The June and September Quarterly Reports identified the following companies as having breached GMAC recommendations:

- Aventis CropScience Pty Ltd (2 breaches and 1 Audit)
- Department of Agriculture Western Australia (1 breach)
- Monsanto Australia Ltd (2 breaches and 1 Audit)

One additional organisation will be identified in the December Quarterly Report to be published shortly – University of Western Australia.

(h) Of the two breaches referenced in the September quarterly report, one relates to the University of Western Australia in which the Centre for Legumes in Mediterranean Agriculture had conducted GM lupin trials under Planned Release 74. A summary of the breach investigation and outcomes is at Attachment A.

The second breach is still under investigation and a draft report has been completed but comments from the entity involved must still be sought. A summary will appear in a report for the current quarter.

Question: E01000153

Attachment A

- **Discovery of Volunteer Lupins on Past Trial Sites**

Notification of alleged breach

On 28 September 2000 the Centre for Legumes in Mediterranean Agriculture (CLIMA), who are responsible for the trials in question, informed the IOGTR that lupin volunteers, which had reached or passed flowering, had been discovered at two sites in Western Australia, near the districts of Mingenew and Quairading.

GMAC recommendations for the lupin trial site

This potential breach relates to the planned release PR74 submitted to GMAC in 1997 for herbicide resistant lupin trials to be run in 1997 and 1998. The lupins have been the subject of a number of field trials by CLIMA which is now operating as a centre within the Faculty of Agriculture, University of Western Australia.

GMAC recommendations require post trial monitoring of the sites for two years. During this time volunteer lupins are to be destroyed before flowering. Monitoring and removal of volunteers at the two sites in Western Australia did not meet this requirement.

The investigation

The original project manager for the sites resigned in July 1999. The trial sites were under interim management from July 1999 until July 2000. A new project manager was appointed in July 2000 to oversee the various past trial sites. This project manager was also a GMAC member at the time. The project manager wrote to the IOGTR on 28 September 2000 detailing a breach of conditions that had been found and the risk management actions being employed.

The IOGTR wrote to the project supervisor after initial investigations and discussions with GMAC to indicate that GMAC had agreed with the risk management actions being undertaken. It should be noted that the project manager was not present at any GMAC meetings that discussed the breach.

In addition, an IOGTR staff member inspected the Quairading site during the investigation. The inspection found several lupin volunteers that were removed and subsequently destroyed.

The findings

A breach of GMAC recommendations was found during the investigation. The breach relates to the failure to remove lupin volunteers before flowering. GMAC discussed the potential breach and agreed with the proposed management actions being undertaken by CLIMA. It was considered that the breach presented negligible risks to human health and the environment. GMAC has previously indicated in its

advice for PR74 that lupins show only a low level of cross-pollination within the species and that hybridisation with other species does not occur. This significantly minimises environmental risks.

Risk management plan

The risk management actions proposed by the University of Western Australia and agreed to by GMAC for the sites are as follows:

For the Mingenew site:
- The volunteer lupins are to be removed and this is a continuous process as new volunteers are discovered.
- The lupin agronomy trial buffer be slashed out in case pollination occurred.
- Mature lupins from the agronomy trial harvested and destroyed by deep burial in case pollination occurred.

For the Quairading site, the volunteer lupins are to be removed and this is a continuous process as new volunteers are discovered.

Future management actions at the Mingenew and Quairading sites include:
- Property manager/farmer to be made fully aware of the monitoring requirements;
- Sites to be planted to cereal or pasture;
- That there be two years clear of volunteer lupins before monitoring ceases;
- That sites be inspected by the trial manager in August before flowering occurs; and
- That sites be re-inspected by the trial manager in October for additional late emergence of volunteers.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000154**

Topic: IOGTR

Hansard Page: CA 33

Senator Crowley asked:

(a) The report (the IOGTR September Quarterly Report) states that experts were contracted to conduct the monitoring. How many experts and at what costs?

(b) Is it based on a daily cost or is it based on qualification?

Answer :

(a) Three experts have been used as part of the monitoring program: one expert from New South Wales assisted with monitoring at New South Wales sites; one expert from Western Australia assisted with monitoring of Western Australian sites; one expert from South Australia assisted with monitoring in South Australia and Victoria.

The total cost was a flat rate based on the length of time it was expected to take to complete the field monitoring and to input into site reports. The total cost was $8800.

(b) It is based on a daily cost.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000155**

Topic: ALLEGED BREACHES

Hansard Page: CA 34

Senator Crowley asked:

Did you have any other breaches reported to you in the December quarter apart from those that you investigated and found?

Answer:

One additional breach was reported during the October to December quarter. The breach was self-reported by the company involved. The breach is under investigation

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 1: POPULATION HEALTH AND SAFETY **Question: E01000156**

Topic: GMAC

Hansard Page: CA 34

Senator Crowley asked:

Can you give us more detail about the nature of the complaint (regarding the conduct of GMAC's business)?

Answer:

The nature of complaint encompassed issues relating to CSIRO, the Bureau of Rural Sciences (BRS) and GMAC. The allegations made specifically against GMAC related to GMAC's receipt and consideration of advice on risks associated with growing plants that have been genetically engineered to carry viral genes

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 1: POPULATION HEALTH AND SAFETY **Question: E01000157**

Topic: CONSULTANTS

Hansard Page: CA 35

Senator Crowley asked:

Could you give us details of the number of times and costs and who was engaged as consultants by the Interim Office?

Answer:

For the period, 1 July 1999 to February 2001, there were 7 consultants contracted to the IOGTR at a total cost of $894 777 as at end of February 2001. GST is included where applicable.

Consultant	Amount Paid	Status
Dialog Information Technology	$391,616	Current
Harris, WJ	$21,600	Completed
KPMG	$97,957	Completed
Luminis	$8,800	Completed
Luminis	$5,617	Completed
Matthews Pegg Consulting	$304,916	Current
McNiece Communications P/L	$52,978	Current
Swell Design Group	$11,293	Completed

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 1: POPULATION HEALTH AND SAFETY **Question: E01000158**

Topic: CONTAMINATED COTTON OIL

Hansard Page: CA 36

Senator Crowley asked:

(a) What research did you draw on to assure you that contaminated cotton oil, as eaten by cows or humans is of no harm to either?

(b) Could you also provide us with the articles or copies of the research done to show that it was safe and/or copies of the risk assessment?

Answer:

(a) In evaluating the safety of cottonseed oil, derived from glyphosate-tolerant (Roundup Ready) cotton, consumed as food by humans or animals the IOGTR sought expert advice from the Genetic Manipulation Advisory Committee (GMAC). The IOGTR also drew on comments provided by States, Territories, and others in the Australian community consulted on both the application made by Monsanto, and the draft Risk Analysis of the application. The IOGTR also reviewed the risk analysis conducted by the Australia New Zealand Food Authority (ANZFA). Both the IOGTR and ANZFA assessed data provided by the proponent company. The IOGTR also relied on information published in the scientific literature and safety assessments conducted by other agencies, including: the Canadian Food Inspection Agency; the Office of Food Biotechnology, Health Canada; and the Animal and Plant Health Inspection Service, United States Department of Agriculture.

(b) Copies of key documents have been included at Attachment A, and can be supplemented with further articles if Senator Crowley wishes:

Question: E01000158

Attachment A

LIST OF ATTACHMENTS

- Australia New Zealand Food Authority, Draft Risk Analysis Report, Application A355, Food produced from glyphosate-tolerant cotton line 1445. June 2000.

- Interim Office of the Gene Technology Regulator, Risk Analysis of Roundup Ready® Cotton and Roundup Ready/INGARD cotton. September 2000.

- Health Canada, Novel Food Information – Food Biotechnology: Glyphosate tolerant cotton (line 1445), Office of Food Biotechnology. June 1997.

- Canadian Food Inspection Agency, Decision Document 97-21: Determination of the safety of cotton lines with Roundup Ready genes (*Gossypium hirsutum* L.). June 1997.

- Animal and Plant Health Inspection Service, United States Department of Agriculture, Monsanto Petition 95-045-01p to USDA APHIS for Determination of Nonregulated Status of Glyphosate Tolerant Cotton (Roundup Ready) lines 1445 and 1698. Environmental Assessment and Finding of No Significant Impact. July 1995.

- Monsanto Australia Limited, Commercial Release of Roundup Ready Cotton (General Release) application. November 1999.

[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 1: POPULATION HEALTH AND SAFETY **Question: E01000159**

Topic: CONTAMINATED COTTON OIL

Hansard Page: CA 36

Senator Crowley asked:

(a) Monsanto did indicate that it had no idea where the contaminated cotton oil had gone. Has anybody been able to confirm whether the contaminated oil has been exported?

(b) If it was exported, was it labelled as being genetically modified?

Answer:

(a) No

(b) Under Australia's food labelling regime for GM food requirements for labelling of genetically modified foods, under Standard A18 – *Food Produced Using Gene Technology* of the *Food Standards Code,* do not apply to highly refined foods, such as oils, derived from genetically modified products due to the removal of genetic material during the refining process. In addition, foods derived from Roundup Ready cotton have been granted approval under Standard A18. Roundup Ready cotton was approved for commercial release in September 2000 by the Minister for Health and Aged Care.

Senate Community Affairs Legislation Committee

ANSWER TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E01000106**

Topic: STARLINK – DNA AND PROTEIN

Hansard Page: CA 48

Senator Crowley asked:

At some stage could you perhaps provide me with a little bit of paper that tells me why it is safe to find DNA but not protein, which I understood you to say.

Answer:

From a food safety perspective, the difference between the positive detection of StarLink DNA, and the corresponding protein, in foods manufactured from StarLink corn is related to the potential of the protein to cause food allergies. The majority of allergic reactions to food are due to the presence of a particular protein component in the food. In contrast, substances such as DNA are not generally associated with such adverse reactions. The reasons for this are outlined in the following information.

DNA is eaten every day in foods of a biological origin, that is foods derived from either plants, animals or bacteria. For example, vegetables such as tomatoes and lettuce, and cereals such as rice and wheat contain plant DNA while meat and eggs contain animal DNA. In addition, yoghurts and some beverages contain edible microorganisms containing bacterial DNA. All DNA, whether from plants, animals or microorganisms, is composed of the same 4 chemical building blocks, termed nucleotides, commonly referred to as *bases*. When consumed, DNA from any source is nutritionally the same, has always been a natural part of the human diet with no evidence of adverse effects and is therefore not of concern, *per se*, with respect to food safety.

Proteins, sugars and fats are also major natural components of most foods, along with the minor components such as DNA. It is known that particular proteins present in food are generally the cause of virtually all known food allergies, therefore the potential of any new protein to give rise to a food allergy is evaluated as a normal part of the safety assessment process for foods produced using gene technology.

In the case of StarLink corn, the introduced genetic change results in the production of a single new protein (of bacterial origin) in the corn. Studies on the potential allergenicity of the new protein revealed that, although it was unlikely to be allergenic, this possibility could not be entirely excluded by the results. As a result, StarLink corn was approved by the USEPA only for animal feed and industrial uses.

Question: E01000106

In the United States, the testing of foods that may have been inadvertently produced using StarLink corn relies on the detection of extremely small amounts of plant DNA. This test is sufficiently sensitive to enable scientists to identify StarLink corn (including the new gene) from conventional corn DNA. To date, using the most sensitive laboratory tests available for the detection of protein, the new protein in StarLink corn has not been detected in processed foods.

From a food safety perspective, as food allergies are associated with the presence of proteins, and the introduced protein in this case did not meet all requirements with respect to likely allergenicity, a positive detection of the new protein in the human food supply would be of greater concern. The positive detection of the genetic material, DNA, is not considered of itself to pose any significant public health or safety concerns.

Senate Community Affairs Legislation Committee

ANSWER TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 1: POPULATION HEALTH AND SAFETY Question: E01000107

Topic: STARLINK - MANUFACTURERS

Hansard Page: CA 49

Senator Forshaw asked :

Are you able to provide the responses or the information that was provided to you by those companies? You may want to take that on notice

Answer:

See attached

Question: E01000107
Attachment

Paul Brent 287

Tricon

Restaurants International

Tricon Restaurants Australia Pty Limited A.C.N. 000 674 993
Kentucky Fried Chicken Pty Limited A.C.N. 000 587 780
Taco Bell Pty Limited A.C.N. 009 064 706
20 Rodborough Road (Locked Bag 522)
Frenchs Forest NSW 2086 Australia
Telephone: (612) 9930 3000 Facsimile: (612) 9930 3001

27th September, 2000

Mr. Michael Dack
Australia/New Zealand Food Authority

Fax: 02 6271 2278

Dear Michael,

I am writing to you in response to your recent call regarding the publicity surrounding the production of Taco shells in the U.S.A from a genetically modified grain source. Taco Bell Australia does not import taco shells from the U.S.A. nor do we use imported grain in the production of our taco shells.

Taco Bell Australia uses maize grain that is grown & sourced locally from a non Genetically Modified seed to produce taco shells for our Australian restaurants.

Please find attached a fax to our supplier Rositas from the Australian Agricultural Service (supplier of the grain) to certify that the maize grain used to produce our taco shells is not grown from Genetically Modified seed.

Yours sincerely,

GREG CREED
Chief Marketing Officer &
General Manager Operations Taco Bell

Attch:

ADDRESS
PO Box 15
Darlington Point
NSW 2706
Woodlands
Sturt Highway
Darlington Point

TELEPHONE
Tel (02) 6968 4196
Mob 018 696 350

FACSIMILE
Fax (02) 6968 4100

WEB PAGE
http://www.
asglobal.com

E-MAIL
russellc@
webfront.net.au

ACN
082 818 059

ABN
47 082 818 059

Charles Barton
Rositas Australia
4 Mcdowals Road
Bendigo Victoria

Dear Charles

This letter is to certify that none of the maize grain supplied to you is produced using Genetically Modified seed.

Our Company, Australian Agricultural service, Trading as "Woodlands Foods" is Quality Assured company under the AS/NZS ISO 9001:1994 standard. Our certification number is, 667.

We have the procedures and systems in place to verify this assertion and would be happy to demonstrate this to you.

Yours sincerely

Kim Russell

20-9-2000.

Managing Director Aust-Ag-Service.

Senate Community Affairs Legislation Committee

ANSWER TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February 2001

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E01000108**

Topic: APMAIF

Hansard Page: CA 51

Senator West asked:

I see that Amcal has also withdrawn as a signatory to the MAIF. Why did they withdraw?

Answer:

As stated in the latest APMAIF Annual Report 1999-2000 (page12), Amcal withdrew from being a signatory to the MAIF Agreement as they underwent a change in ownership, which took effect on 1 July 1999. Snow Brand Pty Ltd which is a signatory to the MAIF Agreement, is now responsible for manufacturing the Amcal and Guardian Brand of infant formula.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000150**

Topic: PSUEDOEPHEDRINE

Hansard Page: CA 53

Senator West asked:

(a) What is happening with the sale of pseudoephedrine in pharmacies in this country in various formulation, formulae, products? Is it still schedule 2?

(b) What action is to be taken in South Australia to make it harder for people to get a psuedoephedrine product?

Answer:

(a) A change in the availability of pseudoephedrine products to the Australian community has been given effect under State and Territory legislation following the publication of a decision of the National Drugs and Poisons Scheduling Committee (NDPSC) in Amendment 1 to the Standard for the Uniform Scheduling of Drugs and Poisons N0 15 (effective date 1 September 2000). All States and Territories adopted the decision.

The decision rescheduled to Schedule 4 (Prescription only) psuedoephedrine when it is the only therapeutically active substance in divided preparations (other than slow release preparations) and when in pack sized of greater than 30 dosage units.

Previously there had been no limit on the pack size available as Schedule 2.

The change did not affect the availability of other preparations previously available as Schedule 2 such as:

- Multicomponent cough and cold preparations;
- Liquid single component preparations; and
- Slow release formulations.

(b) At the National Drugs and Poisons Scheduling Committee meeting where this change in scheduling was discussed, the South Australian representative indicated that South Australia would not adopt the recommended changes, subsequent to the meeting South Australia has reviewed its position and has now adopted the decision.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000099**

Topic: PREVENTING FALLS IN OLDER PEOPLE

Written Question on Notice

Senator Evans asked:

The 1999-00 Budget allocated $6.6m over four years to reduce falls in older people.

(a) Could the Department provide an estimate on annual hospitalisations due to falls and the average cost associated with each hospital stay?

(b) What cost-savings has the Department forecast or realised from the $6.6m outlay?

(c) Has an evaluation of the program been completed or scheduled?

(d) Could we have a copy of the evaluation?

Answer:

(a) Hospitalisations due to accidental falls accounted for 45,069 episodes of hospital care in people aged 65 years and above during the 1997-98 financial year. An average cost of fall related hospital admissions is not available. However, the Australian Institute of Health and Welfare has estimated that the direct costs associated with falls injury in the 65 plus age group was $687 million for the 1995-96 financial period. This included medical and non-medical costs such as hospital, medical and rehabilitation costs associated with injury, ambulance transport, pharmaceuticals and treatment by health professionals other than medical doctors.

(b) This initiative does not have a savings target. The aim is to prevent falls by improving awareness of the significance of falls among older Australians and to increase knowledge of management and prevention among health professionals, the aged care industry and older people themselves. The Population Health Division within the Department of Health and Aged Care is leading the project, working in partnership with the Aged and Community Care Division, the Health Services Division, Health Care Access and Financing Division and the National Health and Medical Research Council on a range of projects. A diverse range of activities and projects are underway and planned. These include: research on the most effective interventions to prevent falls in institutional and community settings; demonstration projects on ways to implement prevention activities; guidelines for general practitioners doing health check ups on older people on how to identify people at high risk of falling and what action to take to reduce risk factors; information dissemination eg publication of best practice information through a website and a newsletter.

(c) An evaluation is planned for the Initiative.

(d) The evaluation report is not planned for release until 2003-04.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000100**

Topic: FAMILY PLANNING

Written Question on Notice

Senator Harradine asked:

Re answer to question E006 (Supplementary Budget Estimates 22 November 2000)
Re allocations to Family Planning organisations in the 2000-2001 financial year.
Please provide comparative figures for the previous financial year.

Answer:

Commonwealth Expenditure for Family Planning in respect of 1999-2000 and 2000-2001

Organisation	1999/2000	2000/2001
Family Planning NSW	4,630,651	β 4,741,214
FP VIC	1,701,100	β 1,741,716
FP QLD	2,663,925	β 2,727,530
FP WA	1,521,094	β 1,557,412
FP SA	Ψ 1,397,000	ψ 1,463,000
FP TAS	497,625	β 509,506
FP ACT	Ψ 422,000	ψ 442,000
FP NT	352,781	β 361,204
FP Australia	87,143	β 89,224
Working Women's Health	99,065	β 101,430
Australian Catholic Bishops Conference	799,377	β 818,463
Australian Federation of Pregnancy Support Services	∂∂ 132,400	∂ 225,108
TOTALS	**14,304,161**	**14,777,807**

Note: • **All figures for 2000-2001 are GST inclusive.**

Ψ **Amount earmarked as specific purpose funding under the Public Health Outcomes Funding Agreements.**

β **The funding amounts are based on the 1999-2000 funding level for each organisation plus the standard Commonwealth's Wage Cost Index 1 factor of 1.4%. An additional amount has been provided by the Department of Finance and Administration for the purpose of superannuation for those organisations which have continuously been supplemented for the Superannuation Guarantee Charge since 1992-93.**

∂∂ **This figure represents part year funding.**

∂ **The funding amounts are based on the 1999-2000 funding level for each organisation plus the standard Commonwealth's Wage Cost Index 1 factor of 1.4%.**

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 1: POPULATION HEALTH AND SAFETY **Question: E01000101**

Topic: STI – SEXUALLY TRANSMISSABLE INFECTIONS (STI'S)

Written Question on Notice

Senator Harradine asked:

Please provide a copy of the document to guide schools in implementing programs relating to STIs.

Answer:

Attached is a copy of the *Talking Sexual Health – National Framework for Education about STIs, HIV/AIDS and Blood-borne Viruses in Secondary Schools*, as approved by the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD).

sexual health

NATIONAL FRAMEWORK FOR EDUCATION ABOUT STIs, HIV/AIDS AND BLOOD-BORNE VIRUSES IN SECONDARY SCHOOLS

Talking sexual health

NATIONAL FRAMEWORK FOR EDUCATION ABOUT STIs, HIV/AIDS AND BLOOD-BORNE VIRUSES IN SECONDARY SCHOOLS

Acknowledgments

The Framework has been developed by the Australian Research Centre in Sex, Health and Society at La Trobe University, Victoria for the Australian National Council for AIDS, Hepatitis C and Related Diseases (ANCAHRD).

The project team consisted of:

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Project officers/principal writers: Debbie Ollis and Jan Watson
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Ongoing advice and direction was provided by the Reference Group:

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Pamela Rajkowski	Department of Education, Training and Employment, South Australia
Marg Sykes	Catholic Education Commission, New South Wales
Jan Watson	Department of Education, Employment and Training, Victoria

A special acknowledgment goes to the STD/AIDS Prevention Education Project of the Victorian Department of Education, Employment and Training for the generous use of previous work, experience and intellectual property provided for the Framework.

Acknowledgment should also be given to the many people who provided feedback and attended consultations across Australia. A list of these can be found in Appendix: Consultation List.
Edited by Carolyn Glascodine
Designed by Keith Downes Design

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TABLE OF CONTENTS

Executive Summary 4

Section 1: Overview 7

1.1 Purpose

1.2 How to use the Framework

Section 2: Context 11

2.1 Background

2.2 Research

2.3 Clarifying sexuality, sexual health, blood-borne viruses and the links to drug education

2.4 Curriculum context

2.5 Key principles and values

2.6 Policy, guidelines and legislation

2.7 The primary and secondary school divide

Section 3: Key Components 21

3.1 Taking a whole school approach – developing partnerships

3.2 Acknowledging young people as sexual beings

3.3 Acknowledging and catering for the diversity of all students

3.4 Providing an appropriate and comprehensive curriculum context

3.5 Acknowledging the professional development needs of the school community

Key Questions: A Checklist 64

Endnotes 65

Appendix: Consultation List 72

EXECUTIVE SUMMARY

Fairness, respect for others, trust and responsibility as values learnt in the family, social and school environment, are important for young people forming personal relationships. Such values also influence and inform decisions about sexual relationships. However, young people must also have accurate and practical information to protect themselves from sexually transmissible infections (STIs), HIV/AIDS and blood-borne viruses (BBVs) in a rapidly changing world.

Australia has an international reputation for innovation in dealing with the complex issues of HIV/AIDS and related diseases in relation to the diverse needs of its population. The *National HIV/AIDS Strategy 1996–97 to 1998–99* identified young people as a priority for education and prevention interventions, and schools as most likely to provide a comprehensive and effective means of educating for long-term change.[1] It concluded that education and prevention programs should place HIV/AIDS in the context of sexual health, hepatitis C and injecting drug use where appropriate.

Recent research has indicated a cultural shift towards safe sexual practices amongst young people and has shown that they display a greater knowledge about the transmission of HIV/AIDS. However, knowledge of other STIs and BBVs is poor. It is important that young people understand the differences between the hepatides and transmission routes because the infection rate from hepatitis C far exceeds that of HIV/AIDS in Australia. The research also indicates that a substantial number of young people are still engaging in high-risk sexual practices such as unprotected sexual intercourse with casual partners.

To understand some of the reasons for this, the complexity of the social world in which young people make decisions about their sexual health needs to be acknowledged. This acknowledgment should consider the role of alcohol and other substance use and abuse in their social lives. In addition, recent research shows that the 8–11 per cent of students who do not identify as exclusively heterosexual are not having their sexual health needs met by school programs, and that many young people of culturally and linguistically diverse backgrounds are reliant on school programs for all their sexual health information. School programs, which in the past may have focused narrowly on disease prevention, must be expanded to accommodate these issues and needs.

With these concerns in mind, the then Commonwealth Department of Health and Family Services convened a national forum of representatives of government and non-government education authorities, health authorities,

parents and key related organisations in all States and Territories in March 1998. Recommendations made at that forum led to the Australian Research Centre in Sex, Health and Society (ARCSHS), La Trobe University, Victoria being commissioned to develop *Talking Sexual Health: National Framework for Education about STIs HIV/AIDS and BBVs in Secondary Schools.*

The purpose of the Framework is to inform and support education authorities and whole school communities to implement education that reflects the complexity of issues related to STIs, HIV/AIDS and BBVs. The Framework has five key components for the development and delivery of a comprehensive education that focuses on STIs, HIV/AIDS and BBVs, which are based on the most current national and international research. These include:

- Taking a whole school approach – developing partnerships
- Acknowledging young people as sexual beings
- Acknowledging and catering for the diversity of all students
- Providing an appropriate and comprehensive curriculum context
- Acknowledging the professional development needs of the school community.

Each key component is supported by strategic advice, which will help in the reviewing and development of policies, and will help to guide the development and evaluation of curriculum, resources and professional development programs. The Framework will also assist in the development of approaches to support and include the experiences of all students. The Framework is designed to give educational institutions flexibility to treat sensitive issues in a manner that reflects their own ethos.

The study of STIs, HIV/AIDS and BBVs fits firmly into a broad health education curriculum with a particular focus on sexual health. Although all other aspects of health need to be integrated into a comprehensive approach, drug-related issues are an important element when addressing issues of sexual safety and hepatitis C infection. In general all States and Territories place sexuality and related drug education within the learning area of Health and Physical Education. Some States and Territories have used *A Statement on Health and Physical Education for Australian Schools* and *Health and Physical Education – A Curriculum Profile for Australian Schools* to guide curriculum development, or as a basis for their own guidelines.[2, 3] The Statement and Profile provide an important and relevant curriculum context for the implementation of the Framework. They do so because the Health and Physical Education learning area focuses on the significance of personal decisions and behaviours, and community structures and practices in promoting health, including sexual health. Emphasis is placed on the importance of recognising the influence that personal actions, beliefs, attitudes and values held by families, cultural groups and the wider community and public policies have on health.

Some of the aims of this Framework are clearly articulated in a number of the learning goals in the Statement. The Statement also provides commonly agreed-upon key principles and values that are critical to the study of STIs, HIV/AIDS and BBVs within a health education context. These key principles cover diversity, social justice and the provision of supportive environments. School-based programs need to be culturally sensitive and aware of the range of different cultural norms and the implications of these for teaching and learning practices for all groups, but in particular for Indigenous Australian young people.

Schools can make an important contribution to education and prevention initiatives relating to STIs, HIV/AIDS and BBVs. It is important to remember that schools are part of a broader community response to improve the health of young people in Australia. A number of national strategies and frameworks provide a policy and guidelines' context that recognises schools as one partner in this process. These include:

- *National HIV/AIDS Strategy 1996–97 to 1998–99* [1]
- *The Second National Mental Health Plan 1998* [4]
- *Gender Equity: A framework for Australian schools* [5]
- *National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99* [6]
- *National Drug Strategic Framework 1998–99 to 2002–03,* including the *National School Drug Education Strategy* [7, 8]
- *National Strategy for Health Promoting Schools in Australia 1998–2001* [9].

Each document supports a broad health context for education about STIs, HIV/AIDS and BBVs and the promotion of sexual health in an integrated way that recognises the social context. Australian schools have legal obligations to comply with in their provision of these programs. These include legal and moral responsibilities for the 'duty of care' of students under both State and Commonwealth legislation, and anti-discrimination legislation at both state and federal levels which is relevant to the creation and maintenance of safe and supportive learning environments free from harassment and discrimination for all students.

The Framework is designed to assist in the provision of education for secondary school students. However, as health and sexuality education does not suddenly begin in secondary school, it is appropriate and desirable for those involved in the provision of primary education to be familiar with the research and the theoretical understandings presented in this document and adapt it to their needs.

Addressing the key components and developing an understanding of the most current research and the implications for young people will ensure an inclusive and comprehensive school-based approach to education about STIs, HIV/AIDS and BBVs within a broad education context.

SECTION 1: OVERVIEW

1.1 Purpose

The purpose of the Framework is to inform and support education authorities and whole school communities to implement education that reflects the complexity of issues related to sexually transmissible infections (STIs), HIV/AIDS and blood-borne viruses (BBVs). It is designed to assist them in responding to the implications of current research and in providing young people with comprehensive education within safe and supportive school environments. In doing so, the Framework will assist those working in this area to incorporate issues around STIs, HIV/AIDS and BBVs into education addressing the social context in which young people live and make decisions about their health.

The Framework is based on key components for the development and delivery of effective health education focusing on STIs, HIV/AIDS and BBVs. The key components are supported by strategic advice, which will specifically help in:

- reviewing and developing policies
- guiding curriculum and resource development
- planning, implementing and evaluating professional development
- assisting education authorities and schools in planning, developing, implementing and evaluating programs
- developing strategies to support and include all students.

It is recognised that individual schools, education authorities and agencies have their own particular values, needs and requirements. This Framework is not designed to replace these but rather to provide a review of current approaches in the context of what is known about young people and strategies that aim to improve their health. The Framework is designed to give education authorities the flexibility to treat sensitive issues in a manner which reflects their own ethos. It can also support school communities to meet the identified needs of young people in their community.

1.2 How to use the Framework

The Framework is divided into three sections. Section 1 describes the Framework's general purpose and gives suggestions for its use. Section 2 sets the context by providing a summary of relevant research, clarifying key concepts and placing issues of STIs, HIV/AIDS and BBVs in the appropriate curriculum, school-based and policy context, and describes the underlying principles. Section 3 provides strategic advice by outlining the following five interrelated and equally important key components.

1. Taking a whole school approach – developing partnerships
2. Acknowledging young people as sexual beings
3. Acknowledging and catering for the diversity of all students
4. Providing an appropriate and comprehensive curriculum context
5. Acknowledging the professional development needs of the school community.

Each key component is presented with a comprehensive discussion of current research, policies and school-based practice. Each key component is supplemented by strategic advice. The strategic advice, based on current research and practice, can be used by education authorities, school communities and agencies to review, develop and implement effective school-based education programs about STIs, HIV/AIDS and BBVs.

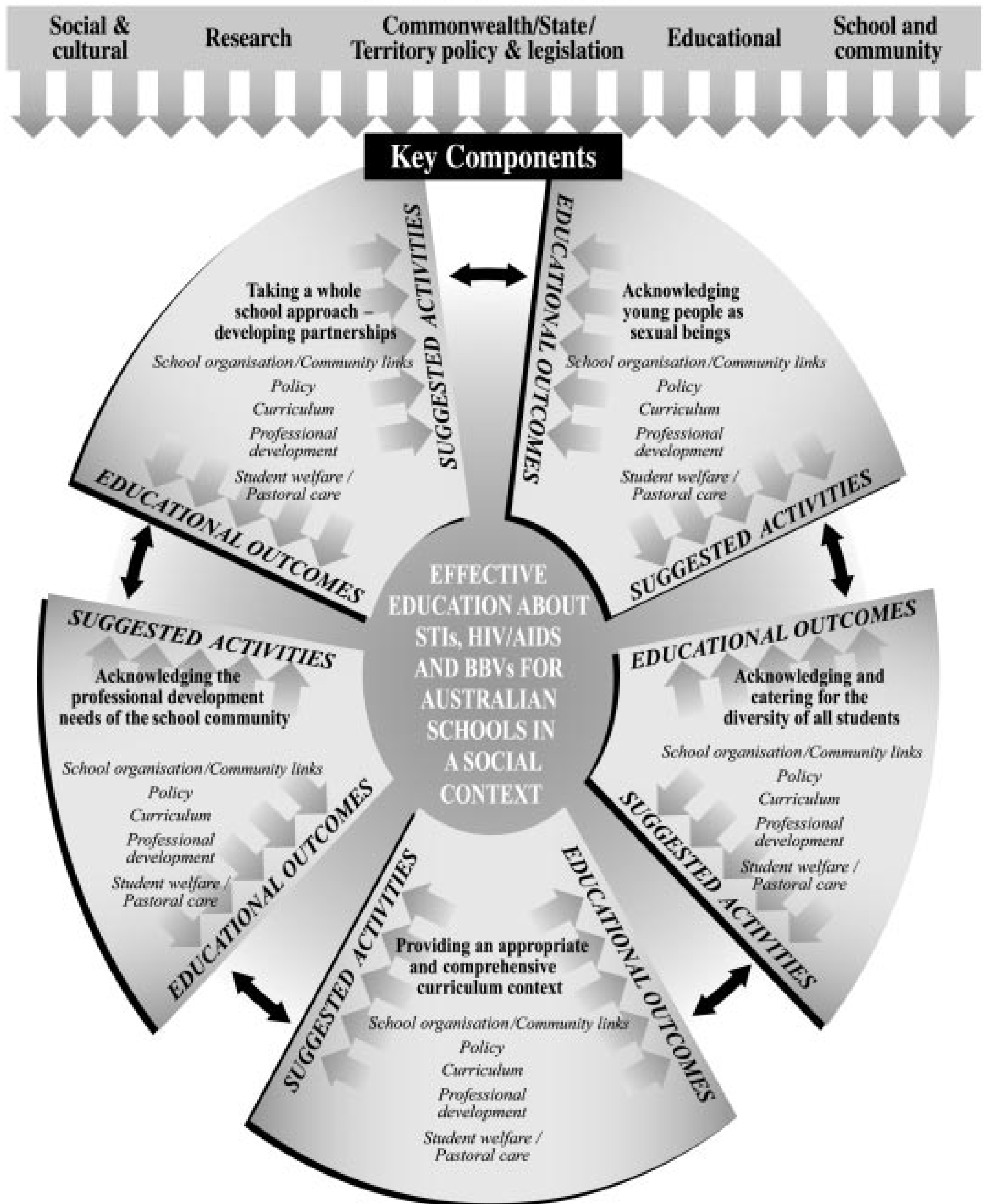
The suggested activities have been grouped into five areas of the whole school environment. These areas are:

- school organisation
- policy and guidelines
- curriculum
- professional development
- student welfare/pastoral care.

As these areas are of equal importance, education authorities and school communities can choose the starting point which best suits their situation. For example, in some school communities classroom-based programs may be in operation with schools and communities looking for suggestions about supporting these programs with appropriate student welfare/pastoral care structures. In other circumstances, education authorities may have formulated or reviewed policy around education about STIs, HIV/AIDS and BBVs and are looking for suggestions about appropriate professional development policies and programs to support policy. Although the starting point and priorities may differ between and among education communities, it is important that all areas of the school environment are considered for the provision of effective education.

Each key component includes a broad education outcome under each of the above areas of the whole school environment and a number of suggested activities for its achievement. The activities presented do not generally recommend specific curricula or outline specific teaching strategies as these can be found in other resources.

NATIONAL FRAMEWORK FOR EDUCATION ABOUT STIs, HIV/AIDS AND BBVs IN SECONDARY SCHOOLS



Although each key component and suggested activities have been presented separately, effective education requires consideration of all the components (refer to the diagram). At a practical level this requires users to cross refer to strategies in each of the other key components. For example, in a review of curriculum programs, as well as considering the suggested activities in key component 3.4 ‘Providing an appropriate and comprehensive curriculum context’, it will be useful to refer to the curriculum outcomes and suggested activities in the other four key components.

A simple checklist has been included at the end of Section 3. It provides a list of key questions to be considered in the evaluation of resources and programs and a summary of key issues from all five components.

SECTION 2: CONTEXT

2.1 Background

Australia has an international reputation for innovation in dealing with the complex issues of HIV/AIDS. A key platform of Australia's approach has been the continuing education programs developed to cater for the diverse needs of the Australian population. The *National HIV/AIDS Strategy 1996–97 to 1998–99* identified young people as a priority for education and prevention interventions.[1] It indicated that such education interventions should place HIV/AIDS in the context of sexual health, hepatitis C and injecting drug use where appropriate. The Strategy also identified school-based education programs as a priority area for further development because education about STIs, HIV/AIDS and BBVs in schools was most likely to provide a comprehensive and effective means of educating for long-term change.

In 1997 the Centre for the Study of Sexually Transmissible Diseases, La Trobe University, Victoria was commissioned to conduct a survey of secondary students in years 10 and 12 in Australian government schools. This survey, *Secondary Students, HIV/AIDS and Sexual Health*, documented their knowledge, attitudes and practices concerning sexuality issues, STIs, HIV/AIDS and related infections.[10] This survey was a follow-up to a survey conducted by the National Centre in HIV Social Research in 1992, *National HIV/AIDS Evaluation 1992 HIV Risk and Sexual Behaviour Survey in Australian Secondary Schools Final Report*.[11] As such, the 1997 survey documented changes in the knowledge, attitudes and practices of young people at the national level over a period of five years.

The findings of the 1997 survey indicate that school-based sexuality education has had an impact on the knowledge, attitudes and practices of young people. The comparison of 1997 findings with those of the 1992 survey showed that there had been a cultural shift towards safe sexual practices among the young people surveyed and that young people displayed a greater knowledge about the transmission of HIV/AIDS. However, there were still many significant gaps in young people's knowledge of other STIs and BBVs and a substantial number of young people were still engaging in high-risk sexual practices such as unprotected sexual intercourse with casual partners.

The results of the 1997 survey are consistent with a number of other recent Australian and international studies. While it appears that school-based health education programs have been successful in increasing young people's knowledge about the transmission of HIV/AIDS, it is still apparent that there is a knowledge – action gap.[12] In other words, although young people have developed knowledge of transmission, they are still engaging in risk behaviours.

To understand some of the reasons for this, the complexity of the social world in which young people make decisions about their health needs to be considered. The structure and content of many existing school-based programs and resources also needs to be examined. To date many of these programs have ignored the broader social context in which STIs, HIV/AIDS, BBVs and sexuality education is situated and narrowly focus on disease prevention instead of health enhancing behaviours. It has been well documented that education on these issues cannot be carried out successfully in schools unless students have the opportunity to examine broader issues such as the social construction of sexuality, gender and power relations, homophobia and other forms of discrimination.

The challenge to develop and implement comprehensive and effective education programs around STIs, HIV/AIDS and BBVs and sexuality is crucial in order to improve the sexual health of Australian young people.

In March 1998 the Commonwealth Department of Health and Family Services hosted a meeting of State and Territory government and non-government representatives from educational authorities and related agencies to consider the implications of the 1997 national survey and to set directions for future action. *Talking Sexual Health: National Framework for Education about STIs HIV/AIDS and BBVs in Secondary Schools* has been developed as a result of the recommendations arising from that meeting.

The consultation and review process through all stages of the Framework development included:

- a survey of key stakeholders in each State and Territory to assess what policies, programs and practices had been developed and implemented in the area
- development and distribution of a discussion paper and proposed Framework for consultation
- conducting a consultation meeting in each State and Territory on the discussion paper and proposed Framework
- distribution of the revised Framework to all those involved in the consultation process for final comments.

The outcome of this process is a Framework that can be used to guide the development of effective education programs about STIs, HIV/AIDS and BBVs in all school communities.

2.2 Research

The findings from a number of national research projects clearly demonstrate a continuing need to address education about STIs, HIV/AIDS and BBVs in schools. Further detail can be found in Section 3.

- Most students have a good knowledge of HIV and AIDS; although many do not know that HIV cannot be transmitted by mosquitoes, that a pregnant woman with HIV can infect her baby, or that a person who looks healthy could pass on HIV.
- Knowledge of STIs and the different types of hepatitis is poor.
- 48 per cent of year 12 students are sexually active with either serial monogamy or a high turnover of sexual partners being the norm.
- 22 per cent of sexually active students have three or more partners in one year.
- Between 8 and 11 per cent of year 10 and year 12 students do not identify as exclusively heterosexual.
- 53.6 per cent of young men in years 10 and 12 and 27.7 per cent of young women in years 10 and 12 used condoms on every occasion they had penetrative sex.
- Alcohol and drug use are major predictors of unsafe sexual practices.
- Of the sexually active young people in years 10 and 12, 13 per cent binge drink once a week or more, have sexual intercourse with casual partners and use condoms inconsistently or not at all.
- Students are still relying on trust and monogamy as a safe-sex practices.
- Students are ignorant of safe sexual practices other than condoms to prevent HIV/AIDS.
- Attitudes towards condom use are more positive than negative, but use is inconsistent and usually for contraception.
- 18 per cent of young women in year 12 rely on withdrawal as a contraceptive method.
- For many students of culturally and linguistically diverse backgrounds school-based sexuality education programs are the only way they can get information about sexual health issues.
- Discrimination in terms of gender and homophobia are key issues for schools.
- Many students believed there were ‘deserving’ and ‘undeserving’ people with HIV.
- Teachers find it difficult to challenge homophobic attitudes.
- 46 per cent same-sex attracted young people have been abused, with 70 per cent of the abuse occurring in school by other students and 3 per cent by teachers.
- Parents, teachers and school-based programs are major sources of information used and trusted by young people.[13, 14, 15, 10]

2.3 Clarifying sexuality, sexual health, blood-borne viruses and the links to drug education

Sexuality and sexual health

Issues related to education about STIs, HIV/AIDS and BBVs are overwhelmingly related to human sexuality and, in the case of hepatitis C, injecting drug use. The terms 'sexuality' and 'sexual health' are key concepts in the Framework and set the broad parameters for school-based education around STIs, HIV/AIDS and BBVs. The Framework has drawn on the World Health Organization (WHO) definitions which have been widely accepted throughout Australia.

> Sexuality is an integral part of the personality of everyone: man, woman and child. It is a basic need and aspect of being human that cannot be separated from other aspects of life ... [It] influences thoughts, feelings, actions and interactions and thereby our mental and physical health. Since health is a fundamental human right, so must sexual health be a basic human right.
>
> Sexual health is the integration of the physical, emotional, intellectual and social aspects of sexual beings, in ways that are positively enriching and that enhance personality, communication and love.
>
> [It involves] a capacity to enjoy and control sexual and reproductive behaviour in accordance with a social and personal ethic. It involves freedom from shame, fear, guilt, false beliefs and other psychological factors inhibiting sexual response and impairing sexual relationships ... [and the] freedom from organic disorders, diseases and deficiencies that interfere with sexual and reproductive function.[16]

Blood-borne viruses (BBVs) and drug education

An issue in need of clarification is that of blood-borne viruses and their inclusion in a framework predominantly addressing infections contracted through sexual activity. Simply, 'a blood-borne virus is a virus that can be transmitted from an infected person to another infected person by blood to blood contact, including through the sharing of injecting equipment.' [17]

There is a great deal of confusion around the group of viruses known as hepatitis. Young people understand that HIV is a blood-borne virus and that it can be contracted from blood to blood contact, such as from the sharing of injecting equipment.[10] However, their knowledge of hepatitis A and the blood-borne viruses, hepatitis B and C, is extremely poor.[10]

The 1997 survey, *Secondary Students, HIV/AIDS and Sexual Health*, shows that school-based programs have had difficulty in effectively covering issues related to hepatitis with young people. This may be because many education authorities and schools separate sexuality education from drug education. Such separation can result in a lack of clarity as to who is responsible for the development and implementation of school-based programs. For practical reasons, the blood-borne hepatides are often covered under the umbrella of STIs as part of programs looking at HIV/AIDS, rather than through the much stronger links to injecting drug use.

It is not the intention of this Framework to be all encompassing of drug education principles and practices. Issues related to drug use need to be considered in any framework that is aiming to provide a comprehensive approach to education about STIs, HIV/AIDS and BBVs particularly because of the link between hepatitis C infection and injecting drug use. More detail on the links with drug education can be found in Section 3.

It is important that young people understand the differences between the hepatides because of the high infection rate from hepatitis C in Australia. Hepatitis C is overwhelmingly contracted through the sharing of injecting equipment, although there is a small possibility of it being sexually transmitted. It is estimated that approximately 80 per cent of injecting drug users are hepatitis C-positive and that about 13 per cent of uninfected users become infected each year.[18] Hepatitis B can be contracted through sexual activity as well as blood to blood contact, such as injecting drug use. While there is a vaccine available to prevent hepatitis B infection, there is no such vaccine for hepatitis C.

Such confusion indicates the need to ensure that education about STIs, HIV/AIDS and BBVs is dealt with in the broad context of an integrated health education curriculum. To do so means examining and integrating issues around physical, mental, emotional and social health for young people. Accurate information about how infections are contracted, detected and where to go for help, as well as how they can be avoided, is crucial to education about STIs, HIV/AIDS and BBVs. Young people who have a positive sense of themselves, who understand their social world and its competing demands, and who are able to communicate and solve personal problems are more likely to make health-enhancing decisions.

2.4 Curriculum context

The provision of education about STIs, HIV/AIDS and BBVs fits firmly into a broad health curriculum. States and Territories vary in curriculum guidelines, syllabus provision and mandated time spent on health education. Even so, all States and Territories place sexuality and drug education within the learning area of Health and Physical Education.

Some States and Territories have used *A Statement on Health and Physical Education for Australian Schools* and *Health and Physical Education – A Curriculum Profile for Australian Schools* to guide curriculum development, or as a basis for their own guidelines.[2, 3]

The development process of the Statement involved national collaboration with all education authorities and facilitated the integration of issues around gender, cultural and linguistic diversity, Indigenous Australians and disability into the main body of the documents rather than in separate and isolated sections. The Statement provides an important and relevant curriculum context for the implementation of the Framework. The learning area focuses on the significance of personal decisions and behaviours and community structures and practices in promoting health, including sexual health. Moreover, it emphasises the importance of recognising the influence that personal actions, beliefs, attitudes and values held by families, cultural groups and the wider community and public policies have on health. According to the Statement 'an understanding of the beliefs, practices and policies in the area of health allows people to play an informed part in public debate and take individual and collective action necessary for emotional, mental, physical, social and spiritual well-being, both personal and social'.[19]

The Framework draws on similar theoretical understandings about young people and health. In particular, a number of the learning goals in the the Statement clearly articulate some of the aims of the Framework.

These include assisting young people to:
- develop the knowledge and skills to make informed decisions, plan strategies and implement and evaluate actions that promote growth and development, effective relationships and safety and health of individuals and groups
- take an active part in creating environments that support health and contribute to community debate and discussion on these issues
- accept themselves as they grow and change, and promote their own and others' worth, dignity and rights as individuals and as members of groups
- evaluate the influence of diverse values, attitudes and beliefs on personal and group decisions and behaviour related to health
- develop an understanding of how individuals and communities can act to redress disadvantage and inequities in health and access to health care and resources
- use and evaluate services, products and facilities that promote well-being.[20]

2.5 Key principles and values

Any area that examines issues related to social life will involve individual and community decision-making. In making decisions and taking action, community, family and individual values are important considerations. Issues around STIs, HIV/AIDS and BBVs are no exception to this. Not only do these issues reside in the area of health but their very nature means that issues around the social context of sexuality and drug use will need to be examined. This process of examination brings with it many differing value positions because 'people's values underlie the judgments they make in everyday life. This means that valuing is an important process, relevant to decision-making, that needs to be taught.' [21]

According to Lemin et al. (1994), 'values are determined by the beliefs we hold. They are ideas about what someone or a group thinks is important to life and they play a very important part in our decision-making.' [22] Even though our values are central to who we are and how we act it 'is not uncommon for people to find it difficult to identify and state what their values are'.[23]

Learning strategies underpinned by a values approach can help students understand this process and make choices and take actions to support values important to themselves, their family, their school, and the broader community. It also assists young people to understand that community values can be an important dimension of the social, cultural and spiritual identity of a person.

Often there is confusion between teaching valuing as a process and teaching for particular values or for a certain value position. Consideration of the teaching of particular values is a sensitive issue and requires clarification and agreement by the whole school community. School communities need to have the opportunity to clarify their own values as they relate to young people and their sexual safety as these will impact on policy and program development and implementation.

In the discussion about values it is understood that some values are generally approved of as appropriate guiding principles, sometimes called 'procedural values'. Other values, which differ from person to person, are sometimes called 'substantive values'.

In education about STIs, HIV/AIDS and BBVs many of these can relate to issues around sexuality, drug use, gender, relationships, discrimination, illness and death. Examining personal and community values is an important process in this area as it enables young people to understand their own values, those of others and the impact these have on personal and community decision-making. The process of valuing and teaching young people these skills can require careful and sensitive treatment at school and in classrooms and require skilled health education teachers.

The Statement and Profile are relevant because they provide a commonly agreed-upon set of key principles and values important to the study of STIs, HIV/AIDS and BBVs within a sexuality education context.[2, 3] The inherent principles and procedural values in the Statement and Profile have been used to guide the development of this Framework. The key principles of diversity, social justice and the provision of supportive environments inform the Framework and guide the identification of knowledge, skills, processes and values in those strategies recommended to improve the health of young people.

Diversity

Understanding diversity involves:

- recognising the cultural and social diversity of society and examining and evaluating diverse values, beliefs and attitudes
- recognising the contribution of social, cultural, economic and biological factors to individual values, attitudes and behaviours
- exploring different views about issues such as gender roles, physical activity, peer-group relationships, sexuality, cultural beliefs and what constitutes a healthy environment
- exploring conflicting values, morals and ethics for well-being when making decisions.

Social justice

Promoting social justice involves:

- concern for the welfare, rights and dignity of all people
- understanding how structures and practices affect equity at personal, local and international levels
- recognising the disadvantages experienced by some individuals or groups (for example remote communities or people with disabilities) and actions to redress them
- understanding how decisions are made and priorities established, and how these affect individual, group and community well-being.

Supportive environments

Establishing supportive environments involves:

- recognising the home, school and community as settings for promoting health
- consultation, interaction and cooperation between the home, school and community and participation of parents and care-givers in the development of school programs and approaches to teaching and learning
- sensitivity to personal and cultural beliefs in dealing with some issues in the Health and Physical Education area
- recognising the crucial role that supportive physical and social environments play in enhancing personal growth and development, physical activity, effective relationships and safety

- understanding the responsibilities of communities in caring for the natural environment
- creating physical and social conditions which support students' own well-being and that of others.[24]

2.6 Policy, guidelines and legislation

Schools can make an important contribution to education and prevention initiatives relating to STIs, HIV/AIDS and BBVs. It is important to remember that schools are part of a broader community response to improve the health of young people in Australia. A number of national strategies and frameworks provide a policy and guidelines' context that recognises schools as one partner in this process. They have been used in the development of this Framework to ensure that education authorities, agencies and schools are provided with a consistent and complementary approach to improving the sexual health of Australia's young people.

Of particular relevance are:

- *National HIV/AIDS Strategy 1996–97 to 1998–99* [1]
- *The Second National Mental Health Plan 1998* [4]
- *Gender Equity: A framework for Australian schools* [5]
- *National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99* [6]
- *National Drug Strategic Framework 1998–99 to 2002–03* and the *National School Drug Education Strategy* [7, 8]
- *National Strategy for Health Promoting Schools 1998–2001* [9].

Australian schools have legal obligations to comply with in their provision of safe and supportive environments for students. Effective provision of education about STIs, HIV/AIDS and BBVs involves the examination of legal as well as moral and ethical issues around sexuality, so it is likely that issues such as discrimination may arise and they need to be addressed.

Schools are both providers of services and are employers, and have legal and moral responsibilities for the 'duty of care' of students under both State/Territory and Commonwealth legislation. Anti-discrimination legislation at both State/Territory and federal levels is a relevant framework for creating and maintaining safe and supportive learning environments free from harassment and discrimination for all students.

Of particular relevance are:

- *Commonwealth Racial Discrimination Act 1975*
- *Commonwealth Sex Discrimination Act 1984*
- *Commonwealth Human Rights and Equal Opportunity Act 1986*
- *Commonwealth Disability Discrimination Act 1992.*

Schools also need to be aware of relevant anti-discrimination and equal opportunity legislation in each State and Territory and incorporate them into school-based policies and practices.

2.7 The primary and secondary school divide

This Framework is designed to assist in the provision of education for secondary school students. However, the division between primary and secondary education is often arbitrary. For example, States and Territories have different levels for the beginning of secondary education: in some States and Territories it is year 7; in others it is year 8, and there are other school structures with no divide, for example first year of school to year 12 colleges.

Sexuality education does not suddenly begin in secondary school. The role of primary school programs cannot be underestimated as they form the basis for secondary school programs. So it is appropriate and desirable for those involved in the provision of primary education to be familiar with the research and the theoretical framework presented here. Content may differ for primary and secondary classrooms but the principles, issues and skills development being promoted to assist young people to make health-enhancing decisions about their sexuality will remain constant.

Education programs and practices should not treat all primary school students as a homogeneous group. Issues around socio-economic conditions, gender, geographic isolation, culture, disability and differing ages of maturation and puberty make it impossible to develop an all-purpose education that begins at age 12. In some schools, where large numbers of students leave at the age of 15, programs will need to begin early to ensure that the young people have access to a comprehensive, sequential program that has given them the opportunity to develop the knowledge and skills necessary to maintain or improve their sexual health.

SECTION 3: KEY COMPONENTS

This section provides a detailed discussion of the current research relevant to the provision of effective education about STIs, HIV/AIDS and BBVs for Australian secondary school students. It provides suggested activities related to achievable outcomes to assist education authorities and school communities to implement effective education in this area.

The Section is divided into five interrelated and equally important components designed to provide the necessary guidance to review, plan, develop, implement and evaluate effective educational strategies.
These include:

1. Taking a whole school approach – developing partnerships
2. Acknowledging young people as sexual beings
3. Acknowledging and catering for the diversity of all students
4. Providing an appropriate and comprehensive curriculum context
5. Acknowledging the professional development needs of the school community.

Each component is presented with a comprehensive discussion of current research, policies and school-based practice and is supplemented by strategic advice. The strategic advice have been grouped into five areas of the whole school environment. Each of the five areas of the whole school environment includes a broad education outcome and a number of suggested activities for its achievement.

3.1 Taking a whole school approach – developing partnerships

Discussion

Strategies designed to improve the sexual health of adolescents have been shown to be more successful if they are delivered in the context of a whole school approach. This means developing, implementing and reviewing policy and guidelines; consulting and working in partnership with parents, elders and the school community; accessing community resources and involving students.[25, 26, 27, 13, 28, 29]

A whole school approach

A whole school approach means more than the implementation of the formal curriculum. It means ensuring that the messages students learn through the informal curriculum are supported by policy, guidelines and practices in the student welfare and pastoral care areas. For example, it is of limited use for students to examine the implications of discrimination on the basis of sexual orientation if in the playground or during sport they observe no response to or support for a student who is harassed for this reason. Similarly, there needs to be an integration of formal programs within a comprehensive student welfare and support structure so that linking students to community health agencies complements education programs.

Whole school approaches to education about STIs, HIV/AIDS and BBVs vary depending on the specific needs and values of the school community. Sexual health education programs and policies developed to reflect attitudes, values, skills and philosophy of each respective community will assist students to understand and act in their own social environment when making informed and healthy lifestyle decisions.

The importance of policy/guidelines

Strong policy and guidelines development may partially explain the success of school-based programs in HIV/AIDS education. All States and Territories have central policies related to HIV/AIDS. Many schools develop their own policies, consistent with these central guidelines and advice, to match the needs of their specific communities. These policies have been generated in response to State and Territory responsibility in relation to ongoing national HIV/AIDS strategies and in recognition of the importance of a pro-active approach to education for young people. The focus of the educational policies varies enormously. Some States and Territories focus purely on infection control around HIV alone; others include BBVs. Several use a more comprehensive approach that includes infection control issues and guidelines on curriculum and student

welfare issues, such as discrimination and harassment. The importance of a policy/guidelines for accountability cannot be underestimated. Many of the current documents need revision in order to more clearly integrate education into a framework addressing all aspects of education about STIs, HIV/AIDS and BBVs in a whole school approach.

Health promoting schools – linking with partners

Education and health authorities have developed several models of successful whole school approaches to health issues. The Health Promoting Schools model, endorsed by the World Health Organization (WHO), is the one most universally recognised by States and Territories. This model, built on the idea of sustainable partnerships, is centred on the interrelationships of three areas of the school community: curriculum and teaching; school organisation, ethos and environment; and community links and partnerships. In this model, a school promoting sexual health as a goal for all students would develop and maintain a supportive learning environment. This would be achieved by catering for the diverse needs of students and staff, by providing information and services and developing and maintaining an environment built on respect and empowerment. It would also develop and support policy and guidelines designed to provide staff and students with clear codes of ethics, provide information and resources that promote safe sexual practices and ensure sexual health issues are linked to student welfare. This model would also develop the personal skills of staff and students in relation to sexual health and consequent decision-making.

A key to this approach is the development of ongoing and sustainable partnerships within the whole school community. Health services would be reorientated to ensure effective partnerships between health and education authorities, agencies and organisations. Such a school would strengthen community action by involving parents and outside agencies in the school.

Students

A significant component of a whole school approach is student involvement in resource development, planning and program delivery, and also in their role as peer educators. Programs have been found to be effective if peer education is conducted to complement school based approaches.[30]

Gourlay (1996) argues that messages from peers are inherently more likely to be relevant and contextualised and to use appropriate and familiar language and concepts. He also points to the valuable learning experience for young people through involvement in the design and implementation of programs and resources. By involving peers, schools can ‘capitalise on the

recognition that the sexual attitudes and behaviours of young people are strongly related to their perceptions of sexual behaviour of their peers'.[31]

Parents/care-givers/elders

Schools working in partnership with parents acknowledge the role of parents/care-givers and elders as primary educators of sexuality. Studies show that partnerships with parents and the community help to integrate 'consistent and relevant health messages into the home and the community', improve student health, and enable a greater awareness of health issues by students and their families.[32]

Programs implemented and initiated in consultation with parents are more successful and also empower parents.[12] Parents often have difficulty discussing issues concerning sexuality with their children. [33, 34, 35] Yet young people see parents as the most trusted and preferred source of information around sexuality issues, with mothers being used by 70 per cent of young people.[36, 15, 10] Very few same-sex attracted young people, although they would prefer to get information from parents, have easy and/or comfortable access to this trusted source.[14]

Schools can support parents as primary sexuality educators by providing them with current information about a wide range of sexuality issues. Schools working in partnerships with parents alleviate some of the anxiety parents experience from an expectation that sexuality education is their sole responsibility. Furthermore, such programs have the potential to provide parents with skills and knowledge to initiate and carry out informed discussion with their children.

Community health agencies and services

A whole school model is useful because it stresses the important and complementary role that community health agencies have in improving the health of students. Young people trust the information they get from these services although they do not readily access them.[10, 15, 14] Schools and agencies working in partnership can make this trusted source of information more accessible. Students feel more comfortable about using community health agencies if schools have linked these agencies into school-based programs.[13] There are many gains to be made from involving community health agencies in school-based programs as long as clear roles and responsibilities are negotiated between schools and community health agencies. These include increased people resources to schools, accurate information to students and teachers, and connecting young people to their local health services.[30, 13]

Appropriate work in schools by community agencies could include assistance in program, policy and guidelines' planning; advice on resources; referral services; professional development for teachers and parents; and conducting, as appropriate, sessions for students to support existing school-based programs. Community health agencies should not be used in one-off sessions; they should be used as part of a continuing program.

Taking a whole school approach – developing partnerships. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Appropriate strategic partnerships developed to support a whole school approach to education about STIs, HIV/AIDS and BBVs.
Policy/guidelines	Policies on STIs, HIV/AIDS and BBVs cover whole school issues such as curriculum; student welfare and support; professional development; partnerships with community health agencies working with schools and infection control proceedures.
Curriculum	Formal curriculum on STIs, HIV/AIDS and BBVs is supported by policy and guidelines, as well as ethos and practices across the whole school environment.
Professional development	Professional development for the education community focused on the development and maintenance of a whole school approach to education about STIs, HIV/AIDS and BBVs.
Student welfare/ pastoral care	Student welfare and pastoral care structures and procedures recognise the breadth and interrelationship of issues related to education about STIs, HIV/AIDS and BBVs.

SUGGESTED ACTIVITIES

- Coordinate activities, such as interdepartmental reference groups and working parties of education and health departments at central, regional/district and local levels.
- Provide advice and resources to assist schools in developing appropriate whole school approaches that fit within existing State and Territory policies and frameworks.
- Encourage parents to play a complementary role in the sexuality education of students, preferably in interaction with teachers, students, community leaders and community agencies. This could include parent information sessions, use of parent knowledge and experience in dealing with issues of cultural and linguistic diversity.
- Provide information about a range of sexuality issues to parents to support and encourage school-based programs.
- Coordinate the work of schools and community agencies in the promotion of sexual health in schools with clearly defined individual roles and responsibilities. Appropriate work in schools by community agencies could include assistance in program and policy and guidelines' planning; advice on resources; referral services; professional development for teachers and parents; and conduct, as appropriate, sessions for students to support existing school-based programs. Community agencies should not be used in one-off sessions; they should be used as part of a continuing program.
- Develop partnerships with key community groups which impact on school programs; these could be cultural, religious and ethnic groups.

- Review policies and guidelines to ensure that education about STIs, HIV/AIDS and BBVs corresponds to the school ethos and includes advice around student welfare issues; curriculum; partnerships with parents, elders, care-givers, community leaders and community health agencies; and infection control issues.

- Ensure that program development and review (curriculum design and delivery) has input from the whole school community.
- Include education about STIs, HIV/AIDS and BBVs as part of existing or newly developed peer education programs and/or work in schools.
- Ensure that program development and review is based on current research and existing evidence.

- Provide professional development activities for the whole school community to assist in developing an understanding of and the need for a whole school approach to education about STIs, HIV/AIDS and BBVs.

- Develop, implement and review policies, guidelines and procedures to deal with harassment of students on the basis of disability, positive status, gender and real or perceived sexual orientation.

3.2 Acknowledging young people as sexual beings

Discussion

The first step in effective education about STIs, HIV/AIDS and BBVs is to help all young people accept that they are sexual and that their sexual feelings and desires are normal. School-based policies, guidelines and programs should support young people in making informed choices about engaging or not engaging in sexual activity. This means for some young people delaying intercourse until they are emotionally, socially and developmentally ready or as it accords with the values of the communities in which they live. For others, it will mean helping them to accept their sexual feelings and activity and to develop skills to protect themselves.[37] Research indicates that if young people are involved in comprehensive sexuality programs they are far more likely to delay the onset of sexual activity and, if already sexually active, to increase safe-sex behaviours.[38] It is also important to recognise a percentage of students are choosing not to be sexually active.

Young people's ability to participate in safe-sex behaviours, including the decision not to have sexual intercourse, needs to be supported by a climate that affirms their sexuality as a significant component of their identity.

Inclusivity

School-based programs and policies that recognise the sexuality of all students are more likely to succeed. For example, school-based programs rarely include the experiences of the 8–11 per cent of secondary students who are attracted to members of their own sex.[10] Students with disabilities are another group of students whose sexuality is rarely acknowledged.

Sexual experience

The level of sexual activity amongst adolescents has remained fairly stable over the past decade.[39, 37, 11, 10] The 1997 survey, *Secondary Students, HIV/AIDS and Sexual Health*, found that 20 per cent of year 10 students and 48 per cent of year 12 students have had sexual intercourse. Other research has found that the level of sexual activity increases with age. The 1992 survey of year 7–12 students, found that approximately one in every four is sexually active by year 9, around one in four had had penetrative sex by year 10 and one in every nine say they have had penetrative sex before the end of year 8.[11] The Centre for Adolescent Health (1992) found that 8 per cent of boys and 2 per cent of girls in year 7 have had sexual intercourse.[40] If the definition of sexual activity is broadened, then the level is much higher. The 1997 survey found that 77 per cent of year 10 and 88 per cent of year 12 students had experienced passionate kissing and that 60 per cent of year 10 and 79 per cent of year 12 students had experienced sexual touching.[10]

Sexual activity in adolescence may also include sexual activity amongst same-sex attracted youth. Research indicates that 5 per cent of 13- to 18- year-olds have participated in some type of same-sex experience.[37] Hillier et al. (1998) found that 60 per cent of the young people (aged 15 to 18) identifying as same-sex attracted indicated they were sexually active.[14]

Risk practices and safe sexual practices

The findings of the 1997 survey confirm what many other researchers have recognised about adolescents; namely, that young people put themselves at risk of contracting a STI or related infection not because of their level of sexual activity or because they belong to a risk group, but because of their own risk behaviours, most notably the decision to have sexual intercourse without a condom. It appears that the sexual lifestyles of adolescents, such as serial monogamy (short-term sequential relationships which are monogamous) casual partnering and engaging in sexual activity under the influence of alcohol and other drugs are keys to understanding why adolescents are at risk of a sexually transmissible infection.[41 11, 10]

Between the 1992 and the 1997 surveys there has been a shift towards young people having fewer sexual partners. In 1997, 16 per cent of sexually active young people in years 10 and 12 had three or more sexual partners in the previous year in comparison with 22 per cent in 1992.[10, 11] In 1992 and 1997 young men in years 10 and 12 were more likely than young women in years 10 and 12 to have had sexual intercourse with casual partners. [10, 11] The 1997 survey showed that more year 10 (78 per cent) than year 12 (57 per cent) young people had had sexual intercourse with casual partners.[10]

The number of students, particularly young men, having sexual intercourse with casual partners is a concern. According to the 1997 survey young men have more partners than young women so they may be having sexual intercourse with both steady and casual partners.[10] The 1998 study of same-sex attracted youth showed that 27 per cent of young women and 39 per cent of young men were having sexual intercourse with both young men and young women.[14]

Condom use

The above findings alone do not demonstrate that adolescents are at risk of contracting a STI or related infection. The crucial factor is whether they engage in safe sexual practices and, importantly, whether they consistently use condoms during penetrative sex. Australian research indicates a confusing picture of condom use among young people. The 1997 survey found that condom use among sexually active students in years 10 and 12 had increased considerably since 1992.[10] In 1997, 54 per cent of sexually active students always used condoms and 37 per

cent used them sometimes compared to 1992 data where 43 per cent always used condoms and 42 per cent used them sometimes.[10, 11] However, closer scrutiny shows a more complex and inconsistent picture of condom use amongst secondary students. In both 1992 and 1997, young men were more likely than young women to report that a condom was always used.[10, 11] Specifically, in 1992, 60 per cent of young men in year 10 and 52 per cent in year 12 reported that a condom was always used compared to 41 per cent of young women in year 10 and 28 per cent of year 12.[10, 11] In 1997, 73 per cent of year 10 and 56 per cent of year 12 young men compared to 41 per cent of year 10 and 44 per cent of year 12 young women reported that a condom was always used.[10] Although the percentage of students who never used a condom has decreased significantly in the last five years, 4 per cent of year 10 and 7 per cent of year 12 young men, and 5 per cent of year 10 and 9 per cent of year 12 young women never used a condom during penetrative sex.[10, 11]

The research literature suggests a number of complex and interrelated reasons, which appear to explain the inconsistency in condom use. These must be considered when developing school-based policies, guidelines and programs. First, it appears that for a significant number of secondary students the motivation for condom use is to prevent pregnancy rather than infection. The 1997 survey found that, although condoms were the most commonly used form of contraception, fewer than one-third of students in years 10 and 12 talked about using condoms to avoid STIs or HIV/AIDS.[10] The 1997 survey indicated that students felt there was no need to use condoms because the contraceptive pill was being used.[10] The 1997 survey highlighted the concern about the 18 per cent of year 12 young women relying on withdrawal as a means of contraception.[10] These findings seem to confirm the observation, made by a number of researchers, that adolescents are behaving in response to the constant threat of pregnancy rather than the threat of infection with new or multiple partners.[42, 11]

Moreover, many young people appear to justify their non-use of condoms in the belief that condoms are unnecessary as their current relationship is monogamous and promises to be long term.[42, 11, 43, 10] Moore and Rosenthal (1993) call this the ‘trust to love’ myth and argue that trust is a significant element in making decisions about condom use.[43] The 1997 survey found that having a steady partner was a major reason for young people not using a condom.[10] This gives rise to additional concern when it is recognised that adolescents change their partners at about three to six monthly intervals and fail to take into consideration their partner’s other current sexual behaviour and activity or their partner’s sexual history.

Related to this, some young people feel that asking their partner to use condoms, or insisting on using condoms, is a sign of 'mistrust, tantamount to implying that the partner may be infected or, at least, sexually promiscuous. Such an implicit lack of trust does nothing for the idealised attitudes of sexuality which many teenagers, especially girls, still hold'.[44]

In addition, students still do not see themselves as being at risk of contracting a STI, particularly HIV/AIDS. The 1997 survey found that students see themselves less at risk now than they did five years ago.[10] Moore and Rosenthal (1993) call this the 'not me myth' and argue that not only do adolescents fail to see STIs and HIV/AIDS as a threat, but that the threat of infection has little to do with their decision to have sexual intercourse.[43]

Alcohol consumption, drug use and sexual behaviour
Between the 1992 and the 1997 surveys there has been a small but statistically significant increase in the number of students reporting not using condoms because they were too drunk or 'high'.[10, 11] The 1997 survey also found that 12 per cent of young women in years 10 and 12 and 14 per cent of young men in years 10 and 12 had engaged in three or more binge drinking episodes in the previous fortnight.[10] This is significant because they also found that binge drinkers were more likely to be sexually active. Of this group, 61 per cent of young women and 64 per cent of young men had had sexual intercourse compared to 18 per cent of young women and 19 per cent of young men who did not binge drink.[10]

In addition, approximately one-third of year 10 students and one-fifth of year 12 students had had sexual intercourse when they didn't want to because they were drunk or 'high'.[10] In 1997, 20 per cent of sexually active students had not used a condom, even though one was available, because they were drunk or 'high'. The 1997 survey showed a small but significant proportion of sexually active students was involved in 'a potentially risky combination of drinking and sex'.[10] In 1997, 13 per cent of sexually active students in years 10 and 12 were binge drinking once a week or more, were having sexual intercourse with casual partners and using condoms inconsistently if at all.[10]

National surveys have shown that between 1 and 2 per cent of 14- to 19-year-olds have injected drugs.[7, 10] In comparison, the drug use patterns of same-sex attracted young people are of concern with 11 per cent of the 14- to 21-year-olds surveyed injecting drugs (of these 12 per cent injected more than three times a week).[7] Many of the young people in this study were using other drugs on a weekly basis. For example, 23 per

cent were using marijuana, 5 per cent 'party drugs' such as ecstasy and 7 per cent heroin on a weekly basis. Statistics in the *National Drug Strategic Framework 1998–99 to 2002–03* show 34 per cent of 14- to 19-year-olds were using marijuana.[7]

There was also a significant gender difference in drug use patterns; with the exception of alcohol, young women used more drugs than young men and more regularly.

Sources of advice

It appears that young people, in particular young men, are reluctant to seek advice around sexuality issues. The 1997 survey found that those who are sexually active are more likely to seek advice than those who are not.[10] Around 48 per cent of young men in years 10 and 12 and 36 per cent of young women in years 10 and 12 had never sought any advice about HIV/AIDS or other STIs.[10] A similar picture exists in regards to seeking advice about contraception, with the exception of young women in year 12. Just over 70 per cent of these young women had sought contraceptive advice. This can also be seen as an indication that young women take more responsibility for contraception than young men do.[10]

Both the 1992 and the 1997 surveys show that overwhelmingly students seek information from parents and teachers. For many students school-based programs may be the only reliable and trusted source of information around HIV/AIDS, STIs and other sexuality issues, particularly for students from culturally and linguistically diverse backgrounds.[13] Hillier et al. (1996) also found that students use the media for information about sexuality issues although they did not trust the information they gained.[15, 10] They also found that, with the exception of mothers, students often did not use the information sources they trusted such as teachers, fathers, doctors and sexual health clinics.

The issue is more complex for same-sex attracted young people. Hillier et al. (1998) found school and the media were the major sources of information around STIs, HIV/AIDS and safe-sex issues for them.[14] Approximately 36 per cent of the sample had received information from school and a further 36 per cent from the media. Only 10 per cent of these young people used their parents as a source of information compared to about 30 per cent of year 10 students and 40 per cent of year 12 students in the 1997 survey.[14, 10] Unlike the heterosexual young people, same-sex attracted young people do not have easy/comfortable access to their most trusted sources of information.

Communication

One of the encouraging findings from the 1997 survey was the increased level of confidence exhibited by students in talking about their sexual health needs.[10] The majority of students were confident that they could

say no to unwanted sexual intercourse and persuade a partner to use a condom. Young men felt less confident than young women in saying no to unwanted sexual intercourse. The 1997 survey reflects changes over the last five years showing that more young people used condoms more regularly than they did in 1992.[10, 11]

Even so, there is a need for caution in making the assumption that young people have developed the necessary skills for effective sexual communication and that they then use them consistently. The 1997 survey confirmed the findings of a number of other studies describing an increase in condom use when young people feel comfortable and able to communicate their feelings about sex. They also found that confidence was gained from being in a steady relationship.[45, 46, 11] However, as Moore and Rosenthal (1993) indicate, such communication is not always straightforward. It can be undermined by 'embarrassment, defensiveness, fear of rejection, the desire to exploit or simply misunderstanding one's partner'.[47] They argue that research reveals many adolescents fail to discuss these important issues during a sexual encounter.

Broadening safe-sex definitions

Although the use of condoms greatly reduces the risk of contracting a STI during penetrative sex, it is not the only option for safe sexual practice. Safe sexual practice appears to be equated with condom use. A number of studies indicate that young people have poor knowledge of the term 'safe sex', or its alternative 'safer sex', and that few young people equate non-penetrative sex with safe sex.[48, 49, 50] It can be considered unrealistic to expect young people to use condoms at all times: 'Educators should continue to emphasise the concept of safe sexual practice beyond sexual intercourse with condoms to include other acceptable and realistic options for young people of both sexes.'[51] By doing this, school-based programs will also affirm the experiences of many young people who are not engaging in penetrative sex as well as those students choosing to delay sexual activity.

Acknowledging young people as sexual beings. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Effective partnerships with the whole school community built on a common understanding and acceptance of young people as sexual beings.
Policy/guidelines	Policy and guidelines' formulation in education about STIs, HIV/AIDS and BBVs articulate the links between promotion of sexual health and the current research on young people.
Curriculum	Program and resource development and delivery reflects the current research on young people and sexuality.

SUGGESTED ACTIVITIES

- Develop partnerships at all appropriate levels to improve the sexual health of young people in schools.
- Work with parents, care-givers, elders and community leaders to include development of a shared understanding of young people as sexual beings and the importance of parents and teachers as trusted sources of information for young people.
- Develop partnerships with local community health agencies and services that enable young people to be aware of and access services to promote their sexual health.
- Review policies and guidelines to ensure that education about STIs, HIV/AIDS and BBVs corresponds to the school ethos and includes advice around student welfare issues; curriculum; partnerships with parents, elders, care-givers, community leaders and community health agencies; and infection control issues.

- Review policies and guidelines to ensure they acknowledge and reflect the realities and documented research about young people's sexual activity and experiences.
- Review and update drug education policies to ensure that the links to STIs, HIV/AIDS and BBVs are clearly articulated with appropriate implementation strategies.

- Review programs and resources so that they reflect and develop in young people a broad understanding of sexuality as part of human relationships.
- Develop new resources and curricula for education about STIs, HIV/AIDS and BBVs, which should reflect current research on young people and sexuality.
- Ensure that future development of resources and programs broaden the definition of safe sexual practices to include information about the range of sexual practices, from penetrative to non-penetrative to delaying sexual activity.
- Develop a curriculum that enables young people to explore the connection between drug use, sexuality and STIs, HIV/AIDS and BBVs.
- Ensure that information provided for students around sexuality and safe sexual practices also includes information that caters for the needs of those groups of students who are often ignored, such as same-sex attracted young people and young people with disabilities.

Acknowledging young people as sexual beings. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Professional development	Professional development in STIs, HIV/AIDS and BBVs includes an acknowledgment that young people are sexual beings.
Student welfare/ pastoral care	Student welfare structures and procedures reflect the research on young people and their sexual health.

SUGGESTED ACTIVITIES

- Provide professional development for the whole school community focusing on the sexual health of young people.
- Provide teachers with professional development which broadens their understanding of adolescent sexuality based on research evidence.
- Offer culturally appropriate programs to parents to focus on young people's sexual health and the importance of their role as primary sexuality educators.

- Encourage student welfare staff to take a health promotion approach in addressing welfare aspects of sexual health, such as display of posters that support all sexualities, having material readily available for all students and working with the classroom teachers in the delivery of programs.

3.3 Acknowledging and catering for the diversity of all students

Discussion

Acknowledging diversity among students is crucial to ensuring that school-based programs are relevant to all students. Diversity refers to the broad range of differences amongst students and their communities and includes aspects related to gender, drug use, race, geographic location, culture, socio-economic background, age, disability, religion and sexuality. Education programs that affirm this diversity, taking into account its implications on young people's social worlds, have greater potential to reach a wider audience of students. Programs should acknowledge that students differ in their personal, social and political experiences and environments, and are not a homogeneous group.

Effective education about STIs, HIV/AIDS and BBVs enhances sexual health within the context of an individual's values, moral beliefs, cultural and religious background, ability, sexuality and gender. Recognition and understanding of different cultural or religious traditions and established values about sexual practices and relationships helps identify specific sexual health education needs. In other words, educational messages will be heard and understood differently by different groups. 'Sometimes it will be gender that filters the message, sometimes it will be our stage of cognitive development, and sometimes it will be our experiences and relationships with the world as influenced by such factors as our culture, ethnicity and the socio-economic milieu.'[52]

Gender

It is impossible to generalise about the gendered experience of sexuality and the implications for safe behaviours because, 'gender differences depend, at least in part, on the particular experience under scrutiny'.[53] However, if successful programs are to be developed for use in schools, gender must be acknowledged and taken into account. Gifford and Jones (1994) argue for an understanding of the effect of gender expectations on relationships, sexuality and safe sexual practices.[54] For example, there is a clear need to challenge beliefs that males cannot control their sexual urges and consequently cannot be expected to take responsibility for contraception. The 1992 survey deplored the possibility that innovative school-based education programs could address the 'very strong but inequitable attitude that females should take primary responsibility in suggesting the use of condoms'.[55] It is evident from the 1997 survey findings that this is still in need of redress.[10]

Research shows that there are many gender issues for young men that need to be considered. Their reluctance to communicate about personal feelings and to take responsibility for contraception and other safe sexual practices limits their possibilities of developing equal, respectful

and supportive relationships. The 1997 survey found that young men expose themselves to high risks of infection from a range of STIs, HIV/AIDS and BBVs.[10] Challenging their perceptions of masculinity and their perceptions of traditional femininity is a critical stage in their education, especially in the context of health and sexuality education. Their education should also include, from a range of curriculum perspectives, the development of critical understandings of gender and power in relationships and the concepts of the construction of gender.[56]

Differing positions of power characteristic of gender relations are central to adolescent sexual behaviour and understanding the inconsistent and variable use of condoms. According to Woodruff (1994), education messages aimed at women which do not examine issues of power inequality and which rely solely on advocating condoms to prevent STIs, HIV/AIDS and BBVs in sexual encounters are doomed to failure.[57] For, as Woodruff points out, ‘power relations in heterosexual relationships are central to the possibilities for heterosexual transmission’.[57]

For Szirom (1988) programs need to examine the underlying attitudes that discriminate against women who make their own choices, such as the choice to be sexually active, and they need to ‘equip men to become full and equal partners in this important aspect of women’s lives’.[58] Thus, we should not assume that assertiveness, for example, is purely a skill to assist young women to say no to unwanted sexual advances. ‘It might mean that, but it may also mean that a young woman can say yes, I want, I feel, I know this about myself.’[59]

It appears that for some adolescents there are gendered motivations for sexual intercourse which affect their use of condoms. Nielsen (1991) suggests that young men are more likely to see intercourse as a way of establishing their maturity and achieving social status, whereas most young women see intercourse as a way of expressing their love or of achieving greater intimacy.[60] She argues that, as a consequence, young men are more likely to have sex with someone who is a relative stranger, to have a number of sexual partners and to divorce sex from love. Shaw (1992) argues that cultural norms of romantic love are important determinants of how women (and men) communicate and behave in intimate relationships.[42] Related to this is the greater level of trust that young women place in relationships. Moore and Rosenthal (1993) argue that because young women take the view that sex is about romance and love, they operate through rose-coloured glasses and on notions of trust.[43] Given young men’s attitudes to sexual relationships described above, relying on trust is considered an unsafe strategy.

Students from culturally and linguistically diverse backgrounds, including Indigenous Australian students

The literature review and consultation feedback indicates that students from culturally and linguistically diverse and Indigenous Australian backgrounds need specific consideration in the planning and delivery of sexuality programs to reduce adolescent risk-taking in relation to STIs, HIV/AIDS and BBVs' infection in mainstream schools. This diversity needs to be acknowledged before schools can develop and implement appropriate intervention strategies. Schools also need to consider the consolidating impact of gender and socio-economic conditions on the experiences and needs of these students.

Available research sheds little light on the sexual experiences of young people of culturally and linguistically diverse backgrounds. Wyn (1993) found that, in one small study, young women of culturally and linguistically diverse backgrounds reported low levels of safe sexual practices.[61] Pedic (1990) reported similar findings, concluding that these young people were more likely than the general community to have negative attitudes towards those people living with AIDS.[62] She also found that they were less knowledgeable about HIV/AIDS and STIs and engaged in more high-risk behaviours. Rosenthal et al. (1990) found lower levels of knowledge among adolescents of culturally and linguistically diverse backgrounds, with young women being even less well informed about HIV/AIDS and safe sexual practices.[63]

This research does not tell us whether the needs of students of culturally and linguistically diverse backgrounds should be met in separate programs. This may be because, as Rosenthal and Reichler (1994) conclude, there are in fact more similarities than differences in the sexual practices and attitudes of young people of culturally and linguistically diverse backgrounds.[48] They caution, however, that findings may under-represent differences because the studies of young people of culturally and linguistically diverse backgrounds groups capture those who 'have succeeded in the predominantly Anglo-Celtic educational system'.[64] Harrison and Hay (1996) found that young men of culturally and linguistically diverse backgrounds were more likely, for example, to display more openly homophobic attitudes.[13]

This lack of research findings and indications has implications for school-based programs. Schools adopt inclusive programs based on raising the self-esteem of students of culturally and linguistically diverse backgrounds through celebration of elements of their culture. Cope and Kalantzis (1988) maintain that this approach rests on an assumption that 'traditionalism and cultural conservation is a good thing'.[65] They find this problematic because it is based on a stereotypical view of culture which sees culture and young people of culturally and linguistically

diverse backgrounds as one-dimensional. Harrison and Dempsey (1998) found students resistant to activities that required them to single out issues that were culturally defined because they did not want to be seen as different.[29]

However, celebrating cultural difference, in the same way as in mainstream curriculum, is not straightforward for teachers in health education. A number of practices either real or perceived, particularly in relation to young women (for instance female genital mutilation) do not sit comfortably with the aims of many health education programs. This is not necessarily a bad thing as Cope and Kalantzis (1988) maintain:

> Cultural differences are not innocent, colourful and simply worthy of celebration. They also embody relations of inequality (p. 153) ... Culture is dynamic as much as it is founded in tradition, and moving away from some aspects of traditionalism (such as racism and sexism) is in all probability a good thing (p. 156).[65]

This problem is often one of perception in which teachers make assumptions about the practices and values of particular cultural groups.[13] Cope and Kalantzis (1988) suggest an approach based on a pedagogical commonsense: 'that students learn what they want to learn and that what they want to learn is very much defined by what is relevant to their own particular cultural context'.[66]

School-based programs need to be culturally sensitive and aware of the range of different cultural norms and the implications of these for teaching and learning practices for all cultural groups, but in particular for Indigenous Australian young people. In many Indigenous Australian communities cultural norms require sexuality education to be conducted in single-sex groups. In some communities single-sex classes may need to be taught by a teacher of the same sex. Such program delivery acknowledges varying traditions amongst different Indigenous Australian groups which can include strict laws for men and women so that 'women's business' and 'men's business' must be discussed separately. Moreover, the *National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99* points out that little research has been done into how behaviour is influenced and changed in these communities.[6] However, the strategy makes it clear that sexuality is a 'sensitive' and 'intimate' issue for Indigenous Australian people and often brings a good deal of 'shame' with it. This makes common classroom strategies such as discussion and role-plays 'awkward and uncomfortable' for these young people.[67]

To cater for the diversity of Indigenous Australian young people 'programs should be designed and developed within a local community context, using local concepts and learning strategies'.[67] According to the

strategy it is 'only possible if local Indigenous people are involved in all stages of program development and delivery'. The strategy also reinforces the importance of 'retaining existing systems and mechanisms that are recognised by community members and strongly embedded in cultural structures and communication networks'.[67]

Education authorities need to establish and maintain procedures for extensive consultation with the appropriate communities, agencies, service providers and health professionals and workers when developing programs specifically targeted at inclusion of the experiences, traditions and values, of not only Indigenous Australian communities, but other cultural groups in their schools.

Religious diversity

The diverse views of religious groups needs to be acknowledged and catered for when developing school-based policies, programs and practices. Often the issues of diverse religious values are ignored because of the perceived difficulty in talking about or acknowledging young people's sexual behaviour when it could be in conflict with religious teaching. This does not mean that young people with strong religious beliefs should not have relevant teaching about health and safety, especially in sexual health.

A key belief across a number of religious traditions is that sexual intercourse is the most intimate expression of love between two people and is only morally and ethically acceptable when it takes place within marriage. Schools catering specifically for young people of a particular religion may base their programs on this belief. It is also important to acknowledge the research that shows a significant number of secondary students are sexually active and have had sexual intercourse.

While it is appropriate for school-based sexuality education programs to take into account the needs and values which the school serves, consideration must also be given to the sexual health education needs of all students. The experience in some State and Territories would suggest that the time spent in community consultation and the negotiation of appropriate school-based programs can lead to innovative local practice. Strong support for programs dealing with the challenge of sensitive issues is often forthcoming from a wide range of community groups. There is an additional benefit in that parents and families and community members become better informed about important health issues, including sexual health, issues.

Developmentally, adolescents are seeking to formulate their own moral and ethical positions on a range of issues that impact upon their lives. Religious teachings will have a significant role to play in this process for

many students. Learning to respect the range of views that people hold in complex areas such as sexuality is an important aspect of education for all students.

Fostering the importance of the partnership of home and school in developing approaches to sexuality education is likely to provide the soundest approach to catering for and acknowledging a range of religious beliefs within a school community.

Students with disabilities

Community attitudes, including attitudes of teachers in schools, mean that many adolescents with disabilities encounter obstacles to the expression of their sexuality.[68] Students with disabilities are often excluded or not catered for in school-based programs because of false assumptions about their sexual health education needs. Sexuality education programs incorporating information and skills development about issues to do with conception, contraception, safe sexual practice, sexual health and prevention of sexual infections and relationships are as important to the lives, aspirations and sense of self for students with disabilities as for those without disabilities. Education authorities need to acknowledge that young people with disabilities have sexual identities and sexual feelings and need accurate information and skills' development just as young people without disabilities.

Bramley et al. (1990) found that a failure to recognise adolescents with disabilities as sexual beings has led to programs which do not reflect their specific needs.[69] They found that, apart from young people with intellectual disabilities for whom there were specific courses, young women with spina bifida, cerebral palsy, or hearing or visual impairment had no information related to their particular disability.

In addition, Grbrich and Sykes (1989) maintain that parents of adolescents with disabilities are over-protective, denying their daughters' and sons' need for sexual health education.[70] They also allude to additional communication difficulties among this group that may hinder the negotiation of safe sexual practices.

Same-sex attracted young people

The majority of existing programs fail to acknowledge the sexual diversity of students. As with heterosexual young people, there is a need to recognise that many gay, lesbian and bi-sexual young people are sexually active. The 1997 survey found that a significant minority, 8 per cent of year 10 students and 9 per cent of year 12 students, was not exclusively heterosexual in their feelings of attraction towards others, and that discrimination and a lack of recognition and affirmation complicated their safe sexual practices.[10]

Dunne et al. (1993) maintained that the one obvious omission from the 1992 study was not including questions about sexual orientation. The report concludes that:

> Clearly, we will not be able to properly evaluate the effectiveness of HIV/AIDS education until researchers, education authorities and school communities can acknowledge homosexuality among young people and, with careful and sensitive planning, carry out studies of social, psychological and educational factors which promote safe behaviours among young gay men who have sex with men.[71]

Hillier et al. (1998) found that same-sex attracted young people between 14 and 21 years are sexually active, with 73 per cent of the sample saying they had had sexual intercourse.[14] This study found that this group was engaging in a number of high-risk behaviours. A particular concern related to the transmission of STIs was the 27 per cent of same-sex attracted women and 39 per cent of same-sex attracted men who were having unprotected sexual intercourse with both males and females.[14]

For these young people, their behaviour indicates they are vulnerable to infection and they are often alienated, harassed, violated, discriminated against or invisible in schools. There also appears to be some evidence that they are at risk of suicide. Gibson (1989) estimates that young gay and lesbian people account for as many as 30 per cent of completed youth suicides a year.[72] The US Task Force on Youth Suicide suggests rates of attempted suicide amongst same-sex attracted young people are six times higher than that of the general community.

Researchers have argued that the problem is caused by a society that stigmatises homosexuality and fails to recognise that there are substantial numbers of gay and lesbian young people.[72, 73] *Suicide Prevention: Victorian Task Force Report July 1997* maintains adolescence is a risk period for same-sex attracted young people because ‘at the same time as acknowledging their sexual orientation they can also be subject to community violence, loss of friendship or family rejection’.[28]

Hillier et al. (1998) found that 46 per cent of same-sex attracted young people had been verbally abused and 13 per cent had been physically abused. Nearly 70 per cent of the abuse had happened at school, 60 per cent by other students, 10 per cent by friends and 3 per cent by teachers. In addition, 40 per cent of the young people did not feel good about their sexual orientation, 18 per cent had never spoken to anyone about their feelings and, of those who had, one-third had experienced rejection of some type. It is not surprising, then, that only 26 per cent of

same-sex attracted young people felt very safe at school, with 14 per cent feeling unsafe or very unsafe at school.[14]

Australian schools are clearly not achieving their goal of providing a safe and supportive learning environment for all students. For gay and lesbian young people it is not only the overt harassment and violence they experience but also their invisibility in mainstream programs. Griffin (1992) argues that the focus on biology and heterosexuality in mainstream literature has meant that the social construction of sexuality has largely been ignored and the reality of gay and lesbian youth denied.[74] Hillier et al. (1998) confirmed this in a study of sexuality education programs in secondary schools which found that schools had great difficulty altering programs to include the experiences of gay and lesbian young people in any holistic way.[13]

According to Willie (1994), 'the debate about including sexual orientation in health education is all about difference, expressing difference and fear of difference. Our society is so simplistic about sexuality and the complexities of sexual orientation and gender orientation and sex-role fit'.[75] Gourlay (1996) maintains that programs assume heterosexuality as the norm with the majority of programs and resources dominated by references to male–female relationships, heterosexual intercourse and contraception.[12] He maintains: 'this may not only reinforce the sense of isolation and difference for young gay men and lesbians, but also deny the rest of the class the opportunity to challenge their own assumptions about sexuality. Heterosexism and homophobia are assaults and constraints that impact on the whole community no matter what our sexual orientation.'[76]

Studies have found that while the process of engaging students with issues around sexual identity was new, students engaged well in such activities, often demonstrating a sophisticated understanding of issues.[13, 29] According to one of the young men in the study, 'I reckon I learned heaps about sexual stereotypes ... how people are expected to be heterosexual ... anyone who isn't is sort of you know like an outcast' (year 10 boy).[77]

Acknowledging and catering for the diversity of all students. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Effective partnerships developed with the whole school community to ensure programs, policies and practices in schools reflect the needs of diverse groups and communities.
Policy/guidelines	Formulation and review of policy and guidelines on STIs, HIV/AIDS and BBVs which acknowledges the need to cater for diversity in implementation strategies for educational institutions.
Curriculum	School-based education programs about STIs, HIV/AIDS and BBVs acknowledge and cater for the needs of all students.

SUGGESTED ACTIVITIES

- Develop productive partnerships with those sectors and community agencies relevant to the cultural groups in the school.
- Establish and maintain procedures for extensive consultation with the appropriate communities, agencies, health professionals, health workers and service providers when developing programs to ensure they are inclusive of or specifically targeted at the experiences, traditions, values etc. of particular groups in their schools.
- Work in partnership with the appropriate state or territory Aboriginal education workers to connect schools with appropriate people in their communities. These could be community organisation chairpersons, community managers, environmental health workers, Aboriginal health workers and community nurses. Two critical groups within Indigenous communities are those of the mainstream structure of local community/Aboriginal and Torres Strait Islander Council and the Indigenous cultural structure.

- Review policies/guidelines, programs and procedures to ensure the information and strategies are inclusive of the needs of all students. Appropriate consultation with cultural, ethnic and religious groups in the communities will enhance the review process.

- Ensure programs are age appropriate, culturally sensitive, respectful of individual choices and include information about the range of sexual practices, from penetrative to non-penetrative to delaying sexual activity.
- Review health education programs and resources to include an examination of the construction of gender and to ensure they are inclusive of same-sex attracted young people and students with disabilities.
- Use available research on young people and sexuality to assist in developing and implementing programs in those schools catering for diverse religious beliefs and practices.
- Ensure teaching and learning strategies are culturally sensitive. For example, discussion may not be the most appropriate for Indigenous young people because of the ‘shame’ attached to issues about sexuality.
- Ensure programs for students with disabilities and indeed all students:

Acknowledging and catering for the diversity of all students. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Curriculum (cont.)	School-based education programs about STIs, HIV/AIDS and BBVs acknowledge and cater for the needs of all students.
Professional development	Professional development in STIs, HIV/AIDS and BBVs enables the education community to understand and develop strategies to cater for the diversity of the student population.
Student welfare/ pastoral care	Student welfare and pastoral care structures and procedures acknowledge and implement strategies to cater for the diversity of student needs in relation to sexual health promotion.

SUGGESTED ACTIVITIES

- are relevant to their physical, intellectual and social/emotional needs
- anticipate the students' future needs
- are part of the continuum of learning for life
- offer opportunities, challenges and choices
- encourage independence while recognising the interdependence of members of the community
- value individual learning styles and preferred learning styles
- provide for different rates of learning
- enhance the student's self-esteem, worth, identity and dignity
- provide for a range of opportunities for individualised and groups learning of skills, knowledge and attitudes
- provide a broad range of experience, processes and approaches
- are realistic, achievable and have clearly stated goals.

- Provide professional development that encourages school staff to critically reflect on their own assumptions and beliefs about young people with disabilities, from culturally and linguistically diverse backgrounds, of Aboriginal and Torres Strait Islander background and diverse religious traditions. They also need to do this in regard to issues of gender and sexuality and towards same-sex attracted young people.
- Provide professional development opportunities around a range of sexuality issues for parents, families and care-givers of young people with disabilities.

- Student welfare personnel work with classroom teachers to develop programs that reflect not only curriculum but build on the welfare issues related to catering for diversity in sexual health.
- Review student welfare and pastoral care procedures and strategies to ensure that they comply with State/Territory and Commonwealth anti-discrimination legislation, with particular reference to the attribute of sexual identity.

3.4 Providing an appropriate and comprehensive curriculum context

Discussion

Education in schools about STIs, HIV/AIDS and BBVs should be consistent with recognised and stated public health goals. This means ensuring that provision of information about infections and viruses is not divorced from the social context in which they occur and in which young people make decisions about both their sexual health and broader health.

It means integrating education about STIs, HIV/AIDS and BBVs into a broad health framework that examines other health issues, such as alcohol and other drug use, instead of only presenting knowledge in a topic-based approach examining STIs as one more negative consequence of sexual behaviour.

Health promotion is the combination of educational and environmental supports for actions and conditions of living conducive for health. A context that is health promoting will 'provide individuals with the knowledge, skills and critical awareness that enables them to make voluntary and informed choices concerning personal and social changes to enhance their health'.[78]

Effective programs

According to Kirby (1992), it is difficult to evaluate those school-based programs which are expected to change personal behaviour.

> Changing behaviour outside the classroom – and especially changing adolescent behaviour with all of the physical and emotional needs that affect it – is clearly a more ambitious and different challenge than improving knowledge and skills. Furthermore, it requires different types of evaluation criteria. Notably, few other classes or programs in schools evaluate effectiveness by observing changing behaviour outside the school.[79]

Research into effective education about STIs, HIV/AIDS and BBVs in schools is fraught because of the controversial nature of its subject matter, sexuality, and the near impossibility of measuring its outcomes. Moore and Rosenthal (1993) maintain that, although there is a policy of providing HIV/AIDS-relevant education in Australian schools, the controversial nature of the topic with 'its unique set of social, economic, political and legal problems makes it difficult to implement any type of program, let alone effective ones'.[80]

Studies show that there is an increase in student knowledge about sexuality and sexuality-related issues following formal programs.[81] Nevertheless, the impact of these programs on attitudes, skills and behaviours is more difficult to ascertain. Kirby (1992 – 93) maintains that many early HIV/AIDS education curricula relied heavily upon group discussions and passing on information about HIV/AIDS, with little attempt to improve communication skills or to change behaviour.[25] They were based upon the assumption that dispelling myths about HIV/AIDS would change behaviour. Evaluation of these programs, according to Kirby, indicates that they increased young people's knowledge, made them more sensitive to HIV-positive people and reduced unnecessary fears about transmission. However, they had little impact on adolescent relationships and sexual practices.

Researchers agree that programs based on a model that contextualises issues and provides students with situational skills is far more likely to be effective than the provision of information alone. Studies show that students not only enjoy this approach but feel they retain more knowledge from those discussions and activities requiring them to reflect on their own and others' feelings and attitudes. Using activities which approximate those situations, students could easily encounter in their daily lives facilitates understanding of difficult conceptual content.[25, 13, 29]

Education programs about STIs, HIV/AIDS and BBVs need to be based on a conceptual framework that:

- develops sequentially in young people the ability to be able to make informed personal choices based on accurate information, their own values' structure and an awareness of what feels comfortable and appropriate, as well as an appreciation of how this can impact upon themselves and others [82]
- places decision-making and values' clarification activities in a relevant social context
- draws on experiential learning, inquiry, goal-setting, modelling and role-play [12, 13, 29, 27]
- has a dynamic and compelling curriculum [12, 13, 29]
- has skilled teachers who are qualified, comfortable, sensitive and trusted by students [43]
- recognises the complementary role that parents can play [32, 36]
- provides a classroom climate which enables students to feel confident and comfortable that their views will be respected and confidentiality will be maintained [27, 13].

Increasing knowledge

The findings of the two national surveys in 1992 and 1997 are consistent with other available research. They tell us that students, in general, are very well informed about HIV/AIDS and its transmission with few

differences in knowledge based on gender and age differences.[10, 11] The 1997 survey found the range of understandings included that the virus could be transmitted sexually or through the shared use of needles or syringes in injecting drug use and that condoms provided protection from HIV during penetrative sex. As the level of knowledge had increased over the five-year period, the 1997 survey maintains that school-based education programs can make a difference. [10]

Even so, the 1997 survey showed there were several areas where student knowledge was poor. These included the fact that students believed that HIV could be transmitted by mosquitoes, that HIV could not be transmitted from mother to baby during pregnancy and that a healthy looking person could not pass on the HIV virus.[10]

The finding that student knowledge about specific STIs, in particular chlamydia, was poor is of great concern as chlamydia is one of the most common STIs.[10] Fewer than 12 per cent of students knew that chlamydia affects both women and men, and fewer than one-third of young people in year 10 or the young men in year 12 knew that it could lead to sterility in women.[10] While most students knew that people can have STIs without obvious symptoms and that condom use does not provide protection against all STIs, their knowledge of specific STIs was lacking. Young people's lack of knowledge of other STIs (except HIV/AIDS) and hepatitis must be addressed in school-based programs.

This information is not new to researchers, many of whom have found similar results over the last decade. It would appear from these findings that school-based programs have concentrated on HIV/AIDS at the expense of education about other STIs.[83, 84, 85, 11, 43, 86, 15, 13, 29] The other major area of concern arising from the 1997 survey was the very low level of knowledge about the different forms of hepatitis, how they were transmitted, their consequences and for which of the viruses there was a vaccine. The only area that students appeared to have some knowledge of was the link between injecting drug use and hepatitis C.

Drug education

Many State and Territory education authorities have separate approaches to education about drugs and education about STIs, HIV/AIDS and BBVs. Although there are good reasons for this, it does little to assist young people make the social connections between drug use, infection, sexual safety and the realities of their social lives. For many young people, drugs are involved in many sexual encounters. As the 1997 survey found, one-third of year 10 students had had sexual intercourse when they didn't want to because they were drunk or 'high' and 13 per cent were binge drinking once a week or more, were having sexual intercourse with casual partners and using condoms inconsistently if at all.[10] Hillier et al. (1998)

found much higher rates of drug use amongst their sample of same-sex attracted young people, particularly among young women.[14]

Moreover, artificially separating issues of sexuality and drug education raises the question of responsibility for the development and delivery of resources and programs, particularly those focusing on hepatitis. Although hepatitis B can be contracted through both sexual contact and the sharing of injecting equipment, hepatitis C is overwhelmingly contracted through the sharing of needles and equipment. If education is to bridge the gap in young people's knowledge of hepatitis and assist them to explore the broader social context in which decisions about drug use and sexuality are enmeshed, programs must take a more holistic approach.

Attitudes towards people living with HIV/AIDS

The 1997 survey showed that most students held unprejudiced attitudes towards people living with HIV/AIDS, although on all measures of attitudes young women expressed slightly more tolerant views.[10] The survey found students had developed more tolerant attitudes towards the possibility of a friend and/or schoolmate having HIV. However, students were less tolerant towards HIV positive people working with young people. They displayed intolerant, if not ambivalent, attitudes to the question "People with HIV only have themselves to blame".[10] Hillier et al. (1996) found similar attitudes in their sample of rural students but were concerned by the 43 per cent of students who agreed with or were unsure about the statement 'people with HIV have only themselves to blame'.[15]

It is crucial that students have the opportunity to explore values, attitudes and myths associated with HIV transmission and the implications for those living with the virus. This indicates the need to ensure that school-based programs do not isolate knowledge from the broader social context around HIV/AIDS. It is increasingly important that schools not only address issues of living with HIV/AIDS but also those associated with other blood-borne viruses such as hepatitis C.

Providing an appropriate and comprehensive curriculum context. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Effective partnerships across the whole school community support a comprehensive health promotion approach to education about STIs, HIV/AIDS and BBVs.
Policy/guidelines	Formulation of policy and guidelines on STIs, HIV/AIDS and BBVs which clearly articulate a rationale and strategies for the provision of formal education within a comprehensive health education curriculum.
Curriculum	Curriculum reform in education about STIs, HIV/AIDS and BBVs provided in the context of comprehensive health education.

SUGGESTED ACTIVITIES

- Establish committees, working parties and reference groups between health and education authorities at all levels to plan, review and implement curriculum.
- Encourage students, parents, care-givers, elders and community leaders to participate in program development at the school level.
- Provide structural support for Aboriginal health workers and other ethnic health workers to assist schools in providing culturally appropriate health education.
- Provide support to enable the provision of appropriate spaces and classroom organisation to facilitate discussion of sensitive issues.

- Review existing policies to ensure that STIs/BBVs form part of HIV and AIDS policy/guidelines.
- Review existing policies to ensure that policy and guidelines on STIs, HIV/AIDS and BBVs include information on curriculum provision in schools.

- Provide opportunities for all students to be educated about STIs, HIV/AIDS and BBVs within the context of comprehensive health education.
- Develop opportunities for cross-curricula work to enrich programs in health education; for example through liaison and cooperative work with drama, English and science learning areas.
- Review existing curriculum and resources to ensure issues around STIs, HIV/AIDS and BBVs are presented in the context of health education advocating a health promotion approach. This would still incorporate teaching about risks to sexual health and would also be explicit about varieties of sexual behaviours, safe sexual practices, sexual orientation and other topics considered to be controversial.
- Develop a curriculum on STIs, HIV/AIDS and BBVs in the context of health education curriculum ensuring that links are made between other health-related behaviours, such as drug education, depression and sexuality, in a broad social context. Particular emphasis to be placed on safe-sex issues and drug use, HIV/AIDS-related discrimination and gender-related discrimination with specific attention given to strategies examining the construction of masculinity.
- Review and, if necessary, develop programs and resources that include current information on STIs, HIV/AIDS and BBVs, particularly hepatitis.

Providing an appropriate and comprehensive curriculum context. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Curriculum (cont.)	Curriculum reform in education about STIs, HIV/AIDS and BBVs provided in the context of comprehensive health education.
Professional development	Professional development on STIs, HIV/AIDS and BBVs enables curriculum writers, planners, and those delivering programs to locate education about STIs, HIV/AIDS and BBVs in a comprehensive health education framework.
Student welfare/ pastoral care	Student welfare and pastoral care policy/guidelines and procedures support and complement a comprehensive health education curriculum.

SUGGESTED ACTIVITIES

- Review and, if necessary, develop programs and resources that include current information on STIs, HIV/AIDS and BBVs, particularly hepatitis.
- Review programs to ensure that they enable students to develop a broad context of sexuality issues. This should include aspects such as communication, sexual and emotional intimacy, friendship, companionship, love, shared activities, interests and hopes, independence and personal space, sexual intimacy, respect and learning that the balance of these aspects varies between people and across time and is influenced by community and personal values.
- Encourage and support teachers to use a range of teaching and learning strategies (such as role-plays, case studies and problem-solving exercises) that cater for the diversity of student experiences with emphasis on the need to acknowledge and understand personal and community values and attitudes.

- Provide professional development for those education personnel responsible for the development and delivery of curriculum to enable them to understand a health promoting framework for education about STIs, HIV/AIDS and BBVs.
- Provide professional development for teachers enabling them to develop skills in establishing supportive classroom climates, activity-based learning, decision-making activities, role-play and to understand the need to place these in relevant social contexts.

- Provide opportunities for student welfare staff to be involved in the development and delivery of classroom programs.
- Review student welfare and pastoral care policy and guidelines and procedures to ensure that the curriculum is understood as being linked to those student welfare policies and procedures in place to deal with issues arising as a result of material covered in classroom programs.

3.5 Acknowledging the professional development needs of the school community

Discussion

Successful delivery of effective school-based programs requires skilled teachers who are qualified, sensitive and trusted by students. According to Harrison and Dempsey (1998) students were clear about the attributes required of a good health educator. These include tolerance, understanding, being knowledgable and supporting an interactive classroom environment.[29] Teachers need to be secure in their understanding of sexuality and able to cope with discussion of a wide range of views they do not necessarily share. Teachers themselves emphasised the need for health educators to be well trained and empathic, given the complex and sensitive nature of the curriculum. [29, 6]

The effective implementation of a framework for STIs, HIV/AIDS and BBVs for Australian schools needs teachers who have had comprehensive professional development in a broad range of issues related to health and sexuality education. Professional development was clearly identified by all States and Territories, through the consultative process, as a key issue in need of support. At present, provision of professional development varies in its approach and its content. Generally, all States and Territories provide some central professional development, often in conjunction with community agencies. These agencies include Family Planning Associations, Community Health Centres, Departments of Health and Community Services and universities, some of which offer accredited courses for participating teachers.

Some States and Territories provide professional development at a school-based level within central guidelines. Central professional development is generally planned and delivered around knowledge and awareness of specific infectious disease protocols. Several States and Territories provide a broader approach focused on STIs and HIV/AIDS in the context of sexuality which is compatible with central resources used by teachers in the classroom. Funding ranges from central provision to determination at school level from overall budgets. However, the amount of central funding has diminished in line with devolution and the increasing responsibility and autonomy being given to individual schools. In the non-government sector professional development may be offered in the context of Catholic and/or Christian and/or other religious or philosophical values.

It appears that most of the professional development programs being offered nationally centre on knowledge of HIV/AIDS and BBVs and infection control issues. Research indicates that effective education in this area requires teachers also to have an understanding of the broad context of health and sexuality. Therefore, teachers need more comprehensive

education, not just knowledge of infections. Few teachers have any specialist training in STIs, HIV/AIDS and BBVs education. A curriculum audit carried out in Victoria and Queensland in 1995 found sexuality education to be a major area of discipline renewal requested by teachers.[87, 88]

Gourlay (1996) points out that sexuality education overwhelmingly relies on volunteers and conscripts who are largely expected to train themselves. It could justifiably be argued that sexuality education, 'the most loosely defined and disparate of curriculum areas, is being taught by teachers who invariably feel under-trained, under-resourced and under siege'.[89] Educators in this area face additional difficulties because of the moral and ethical dimensions of sexuality education and a concern that teachers will influence students' values and attitudes. According to Gourlay (1996) we cannot ignore that sexuality educators do hold positions that are reflected in their programs, for example promotion of social justice and opposition to discrimination and violence. However, he maintains that, educators in this area cannot be value-free but should strive to be value-fair, offering a balanced perspective and acknowledging diversity.[12]

It is unrealistic to expect teachers to change their teaching approaches to assist young people to examine the broader social context of issues around STIs, HIV/AIDS and BBVs without adequate and comprehensive professional development. A number of researchers have pointed to the difficulty for teachers in effectively facilitating this with students.[27, 13, 29] Harrison and Dempsey (1998) recommended that professional development programs should not only focus on improving the knowledge base of teachers, but on developing skills to build an appropriate classroom climate, to recognise and cater for the diversity of students, and to link at-risk students to appropriate services.[29] States and Territories also identified the need for updated knowledge and skills in working with students and parents on a broad range of sexuality issues, skills in policy and guidelines development and formulation, the development of materials and resources and focusing on education in this area under a health promotion banner.

Acknowledging the professional development needs of the school community. Strategic advice

WHOLE SCHOOL	OUTCOMES
School organisation, School – community links	Partnerships developed across the education, health and wider community to ensure effective and appropriate professional development in education about STIs, HIV/AIDS and BBVs.
Policy/guidelines	Review and formulation of policy and guidelines in education about STIs, HIV/AIDS and BBVs including a rationale and guidelines for the provision and delivery of appropriate professional development.
Curriculum	Development and delivery of appropriate professional development includes a key component related to the development and implementation of comprehensive curricula.
Professional development	Appropriate and ongoing professional development in STIs, HIV/AIDS and BBVs provided to all members of the school community.

SUGGESTED ACTIVITIES

- Provide professional development for the whole school community to effectively develop and implement a whole school approach to education about STIs, HIV/AIDS and BBVs.
- Education authorities work in partnership with other agencies/institutions such as universities and community health organisations to develop professional development programs for the school community in STIs, HIV/AIDS and BBVs.
- Central education authorities to develop and review and provide to schools a list of accredited providers of professional development in education about STIs, HIV/AIDS and BBVs. For Aboriginal and Torres Strait Islander communities education authorities should develop local networks of trainers and educators and create a register of trainers, speakers and support personnel that might be used to develop local or regional programs (*National Indigenous Australians' Sexual Health Strategy 1996–97 to 1998–99,* p. 8).
- Liaise with teacher training institutions, including universities, to encourage the inclusion of training in education about STIs, HIV/AIDS and BBVs.
- Education authorities support the development and use of parent resources for schools to use.
- Alternative or extra provision of and access to professional development to be made available for teachers working in remote and isolated school/community settings.

- Work in partnership at all appropriate levels to ensure policy and guidelines include a complementary component on professional development.
- Ensure policy in STIs, HIV/AIDS and BBVs enables the provision of and support for professional development to enable all teaching staff access to the knowledge of and skills needed to develop a cross-curriculum approach.

- Education authorities should ensure that professional development in education about STIs, HIV/AIDS and BBVs is linked to other health-promoting initiatives and programs, such as drug education, suicide prevention, mental health promotion, body image issues etc.
- Provide continuing professional development for teachers to upgrade their knowledge and skills related to the development and maintenance of supportive classroom climates.

- Provide professional development for the groups that make up a whole school community which enables them to acquire most of the following:
  - access to current research on young people and sexuality
  - those pedagogical skills to implement sexuality education programs focusing on education about STIs, HIV/AIDS and BBVs for same-sex attracted young people
  - the ability to provide students with accurate information, with opportunities to understand personal attitudes, values and behaviours and to develop skills in decision-making around sexual health issues

Acknowledging the professional development needs of the school community. Strategic advice (cont.)

WHOLE SCHOOL	OUTCOMES
Professional development (cont.)	Appropriate and ongoing professional development in STIs, HIV/AIDS and BBVs provided to all members of the school community.
Student welfare/ pastoral care	Student welfare and support personnel provided with appropriate professional development.

SUGGESTED ACTIVITIES

- an ability to foster comfort levels, to create rapport with students from diverse backgrounds and experiences, and a capacity to respond confidently and respectfully to the sexual health needs identified by specific groups
- the capacity to communicate in a positive and sensitive manner and to affirm that sexual feelings are a natural part of life
- an ability to identify and understand the beliefs and values of individual students which involves sensitivity to the cultural norms, beliefs, attitudes and goals of various racial, ethnic, socio-economic, gender and religious groups
- specific understanding of issues around sexual orientation and skills in providing effective education in that area
- sensitivity to gender-related issues
- insight and skills in helping young people to reflect upon, and evaluate the various ways the media depicts/represents sexuality issues
- an awareness of and ability to refer students to appropriate community health organisations and/or welfare and support services
- an ability to work in partnership with other health agencies.
  (Several points modified from *Canadian Guidelines for Sexual Health Education* 1994)

- Schools should ensure that professional development provided by outside agencies is delivered through accredited providers. Most States and Territories have a list of such providers. If not, schools need to ensure that guest speakers, both for staff and students, complement existing school-based programs and priorities.

- Provide appropriate levels of professional development for central, regional and school-based student welfare and support personnel in student welfare issues related to STIs, HIV/AIDS and BBVs.
- Provide professional development for school-based student welfare and pastoral care personnel to enable them to acquire knowledge of and skills in all aspects of education about STIs, HIV/AIDS and BBVs so they can more effectively work with and support the whole school community.

KEY QUESTIONS: A CHECKLIST

This checklist has been designed as a useful guide for program and resource development and evaluation. It summarises an inclusive and comprehensive school-based approach.

It would be impossible for any one program, activity or resource to fulfil all of the following criteria. However, this checklist can be used to assess and review available resources and programs for their inclusivity and comprehensiveness.

- Does the resource/program acknowledge that students are sexual beings?
- Does the resource/program place STIs, HIV/AIDS and BBVs in the context of sexuality?
- Is the resource/program easily understood by the intended audience?
- Is the resource/program culturally sensitive to the intended audience?
- Does the resource/program include activities that improve knowledge of STIs and other BBVs, as well as addressing the lack of knowledge identified around HIV transmission and perceived risk?
- Does the resource/program form part of a whole school approach to addressing issues of STIs, HIV/AIDS and BBVs and sexuality in schools?
- Does the resource/program use a health promotion approach?
- Does the resource/program address a value position as an integral step in developing sexual health attitudes, decisions and behaviours?
- Does the resource/program include the experiences of a range of students; in particular are same-sex attracted youth included in a holistic way rather than only in relation to infection risk?
- Does the resource/program address issues around homophobia and discrimination?
- Does the resource/program examine the construction of masculinity and femininity and the power dynamics in sexual relations?
- Does the resource/program present a range of safe-sex options?
- Does the resource/program integrate other issues, such as drug use, safe sexual practice and relationships?
- Does the resource/program include strategies to encourage discussion with parents?
- Does the resource/program enable students to examine the sources of information they use and those they trust?
- Does the resource/program enable students to make links to health services?
- Does the resource/program complement the ethos of the school?

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Helen O'Sullivan, Manager, Partners in Education, DOE
Eileen Nash, Principal Nursing Officer, DOE
Maria Marriner, Health and Drug Education, DOE
Kate Miles, Education Officer, Open Education Centre, DOE
Tammy Clarke, Sexual Health Educator, Danila Dilba
Therese Peck, School Registered Nurse, Taminmin High School
Linda Fields, School Registered Nurse, Sanderson High School
Pat Willis, School Registered Nurse, Driver High School
Gina McDonald, St John's College
Robert Weatherald, Driver High School
Bill Parlet, Education and Training Manager, Family Planning Association, NT
Julie Kellam, Nightcliff High School
Sharon Handley, Council of Government School Organisations
Olive Fracking, Health Promoting Schools Steering Committee
Kath Phelan, Executive Director, Association of Independent Schools

Queensland

Chris Payze, Family Planning Queensland
Rod Ballard, Coordinator, Health Issues, Education Queensland
Lois Kennedy, Senior Education Officer, Health & Personal Development, (H&PD) Education Queensland
Christine McConnell, Project Officer, H&PD, Education Queensland
Peter Anderson, School of Public Health, QUT – Kelvin Grove Campus
Rosemary Dillon, QCPCA, Metropolitan West Council
Dr Rod Edwards, Faculty of Education, Griffith University
Ken Ernest, Deputy Principal, Maroochydore State High School
Lisa English, Project Officer – Health Promoting Schools, Education Queensland
Matt Gillette, Executive Director, AIDS Council

Jane Hanson, Principal Policy Advisor – Communicable Diseases, Queensland Health
Bob Logan, HOD – Health & Physical Education, Brisbane State High School
Ann Maree Boyle, A/Senior Education Officer, Behaviour Management, Education Queensland
Phil Carswell, A/Senior Advisor – Prevention Alcohol, Tobacco & Other Drugs, Queensland Health
Tony Kitchen, Catholic Education Commission
Glenn Amezdroz, Head of Department, Health & Physical Education, Anglican Church Grammar School
Jenni Moss, Project Officer, Health Promotion Services, Brisbane North, Queensland Health
Judy Rose, Family Planning, Qld
Rosalie Rositi, Senior Education Officer, ATSIC Branch, Education Queensland
Kay Taylor, Senior Coordinator, Maroochydore State High School

South Australia

Jill Reynolds, Family PlanningAssociation, SA
Kirsty Hammet, HIV & Related Programs Unit, Public & Environmental Health Services
Jill Sanderson, (SHINE)
Ralph Bran, (SHINE)
Judy Kelly, Unley High School
John McKenna, Positive Speakers Bureau
Kelli Rogers, Beafield Education Centre
Corinne Milch, Training and Development Unit, Department of Education, Training and Employment (DETE)
Shirley Dally, Gender Equity Team, Programs and Curriculum, DETE
Anne Young, Curriculum Officer, Health and Physical Education, DETE
Pam Rajkowski, Curriculum Officer, Health and Physical Education, DETE
Ian Fry, West Lakes Shore Kindergarten
Sue Grinwald, Murray Bridge High School
Tracy Wilsdon, Murray Bridge High School
Rosie Montrose, Norwood Morialta High School
Olivia O'Neill, Norwood Morialta High School
Ian Henderson, HIV and Related Diseases, (COPE)
Gail Peters, Family Life
Claire Speechely, AIDS Council
Judith Bundy, SA Association of School Parents' Clubs
Marion McCarthy, SA Association of School Parents' Clubs
Clive Harrison, SA Association of Secondary Schools Organisations
Ross Gleeson, Kybybolite Primary School
Peter Mercer, Catholic Education Office
Chris Lemon, Catholic Education Office
Rowena Fox, OB Flat Primary School
Bronwyn McLean, Woodville High School
Julie Potts, St Peter's Collegiate Girls' School
Barbara Keen, Independent Schools' Board
Robyn Hearl, Gepps Cross Girls' High
Jo Everett, Magill Junior Primary School

Gillian Bonney, Para Hills High School
Nadia Lovett
Jo Everett
Neil Tregenza
Ruth Lenton
Michelle Rogers
Vicki Hughes
Karen Jennings
Joan Cunningham

Tasmania

Virginia Berechree, Scotch Oakburn College
Geoff Frier, Sorell High School
Barb Hortle, Wentworth Support School
Lyn Hanlon, Claremont College
Karen Swabey, Lecturer, University of Tasmania
Brendon Nelson, Tasmanian Council on AIDS and Related Diseases (TASCARD)
Graeme Cooksey, Principal Curriculum Officer, Health and Physical Education, Department of Education, Community and Cultural Development (DECCD)
Phil Tyson, Senior Curriculum Officer, Equity Branch, DECCD
Julie Dunbain, Health Promoting Schools Liaison Officer, DECCD
Karen Collins, Health Education Officer, DECCD
Greg Stephens, Manager, Sexual Health Branch, Department of Health
Jennie Gallivan, The Friends' School and Association of Independent Schools of Tasmania
Majella Kelly, Catholic Education Office
Sue Rockcliff, School Community Liaison Officer, Tasmanian State School Parents and Friends Council
Esme Murphy, Family Planning Association Tasmania
Trish Moran, Australian Education Union
Debra Reid, Aboriginal Health and Wellbeing Outcomes Unit, Department of Health and Human Services
Sue Burke, Family Child and Youth Health Service, Youth Health Team

Victoria

Mandy Stephens, Family Planning Victoria
Margaret Sheehan, School of Nutrition & Health, Deakin University
Peter Roberts, Senior Policy Officer, Student Welfare, Department of Education (DoE)
Jane Weston, Co-Manager, Koorie Education Development Unit, DoE
Gary Shaw, Senior Project Officer, Drug Education, DoE
Cathy Sullivan, Senior Project Officer, Health Promoting Schools, DoE
Jennie Toyne, School Services Officer, Association of Independent Schools of Victoria
Mark McHugh, Public Health Branch, Department of Human Services
Sharon Foster, Manager, Health & Physical Key Learning Area, Board of Studies
Judy Cain, Education Officer, Catholic Education Office
Peter Gourlay, Special Projects Officer, Equal Opportunity Commission
Ian Seal, Education Consultant, Resources, Action Centre
Jim Sotiropoulous, Education Officer, Victorian AIDS Council

Anne Mitchell, Australian Research Centre in Sex, Health and Society, La Trobe University
Marg Sutherland, Centre for Social Health, La Trobe University
Val Webster, Faculty of Education, University of Melbourne
Pam Blackman, Altona Secondary College
Nerida Mathews, Maroondah Secondary College
Linda Carter, Altona Secondary College
Chris Hart, The Grange Secondary College
Suzanne Wright, Health Education Association of Victoria
Mirta Gonzales, Director, Centre for Culture Ethnicity and Health
Lynn Reddon, Victorian Federation of State School Parents' Clubs
Caroline Anderson, Victorian Parents' Council
Debbie Brown, Association of School Councils in Victoria
Jeremy Ludowyke, Principal, Princes Hill Secondary College

Western Australia

Jon Gibson, Senior Curriculum Officer, Health and Physical Education, Education Department of Western Australia (EDWA)
Lorel Maybury, School Drug Education Project, EDWA
Sharyn Burns, School Drug Education Project, EDWA
Bruno Faletti, School Drug Education Project, EDWA
Lorraine Telfer, School Drug Education Project, EDWA
Norma Jeffrey, Director of Curriculum, Curriculum Council of Western Australia
Kathy Kirwin, Family Planning Association, WA
Chris Carter, AIDS Council of Western Australia
Peter Della Vedova, Shelley Primary School
Maryrose Baker, Senior Policy & Planning Officer, Sexual Health Program, WA Health Department
Peter Horacek, Family Planning Association, WA
Nic Randall, Department of Human Movement, University of Western Australia
Peter Blackwell, ACHPER Western Australia
Kim Chute, Health Promoting Schools Association
Dianne Guise, Western Australia State School Organisations

For further information on:

Talking sexual health

NATIONAL FRAMEWORK FOR EDUCATION ABOUT STIs, HIV/AIDS AND BLOOD-BORNE VIRUSES IN SECONDARY SCHOOLS

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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 1: POPULATION HEALTH AND SAFETY **Question: E01000102**

Topic: METHOTREXATE

Written Question on Notice

Senator Harradine asked:

(a) Of the 12 reports of fatal outcomes as a result of the use of methotrexate as reported to the Adverse Drug Reactions Advisory were these in relation to its use in pregnancy termination or other purposes?

(b) Please provide details of the individual cases from the ADRAC published reports.

(c) Please also provide details of the death in connection to the use of Misoprostol.

Answer:

(a) All of the twelve reports related to use for purposes other than termination of pregnancy.

From 1st January 1996 to 21 November 2000 ADRAC received 12 reports of fatal outcomes in connection with the use of methotrexate as follows;

ADRAC Report Number	Reported indication for use of methotrexate
112736	Rheumatoid arthritis
114676	"Anaplastic non-Hodgkin's disease" with suspected cerebral involvement
118575	Rheumatoid arthritis
119567	Rheumatoid arthritis
121723	Lung cancer
129014	Acute lymphoblastic leukaemia
145214	Rheumatoid arthritis
149239	Polymyositis
155161	Rheumatoid arthritis
155716	Rheumatoid arthritis
156730	Rheumatoid arthritis
158777	Crohn's disease

Since the previous cut off date, 21 November 2000, up to 20 February 2001 two further reports of suspected adverse reactions to methotrexate with fatal outcomes were received as follows:

160270	Rheumatoid arthritis
161019	Rheumatoid arthritis

(b) Individual summary computer printouts for the above reports are attached. Also attached is a copy of the explanatory notes which detail the qualifications and limitations which apply to ADRAC information.

(c) The case summary computer printout for ADRAC Report number 90865 is attached. This report describes a fatal outcome in a 78 year old man with a history of rheumatoid arthritis and congestive cardiac failure (due to ischaemic heart disease) who developed hepatitis. Misoprostol (Cytotech) was one of 6 drugs recorded as possible causes. At least one of the other drugs (Floxapen brand of flucloxacillin) is a well documented cause of drug associated hepatitis.

[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 1: POPULATION HEALTH AND SAFETY **Question: E01000151**

Topic: ADVERSE REACTIONS

Hansard Page: CA 68

Senator Knowles asked:

Could we have a copy of the adverse reaction bulletin? (Containing information regarding Celebrex)

Answer:

Copies of the June 2000 and February 2001 issues of the Australian Adverse Drug Reactions Bulletin are provided. Both contain items about celecoxib (Celebrex)

http://www.health.gov.au/hfs/tga/docs/pdf/aadrbltn/aadr0006.pdf

http://www.health.gov.au/hfs/tga/docs/pdf/aadrbltn/aadr0102.pdf

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 1: POPULATION HEALTH AND SAFETY **Question: E01000177**

Topic: CELEBREX ADVERSE REACTIONS

Written Question on Notice

Senator Evans asked:

Can you advise what percentage of ALL ADRAC reports for December 1999 and January 2000 are represented by Celebrex?

Answer:

There were 160 reports of suspected adverse reactions to celecoxib (Celebrex) in a total of 1281 adverse drug reaction reports in December 1999. That comprises 12.5 % of all reports.

There were 119 reports of suspected adverse reactions to celecoxib (Celebrex) in a total of 865 adverse drug reaction reports in January 2000. That comprises 13.8 % of all reports.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000178**

Topic: CELEBREX ADVERSE REACTIONS

Written Question on Notice

Senator Evans asked:

(a) Where is the information gathered by ADRAC disseminated and how is it used?

(b) Is the Minister's Office made aware of this type of information?

(c) Was the Minister's Office briefed on the Celebrex adverse effects information prior to the official ministerial announcement of the product's listing on 1 June 2000?

Answer:

(a) ADRAC is a subcommittee of the Australian Drug Evaluation Committee (ADEC) and minutes of ADRAC meetings are provided to ADEC. In addition, ADRAC distributes the Australian Adverse Drug Reactions Bulletin which is mailed with the Australian Prescriber four times per year.

(b) The Minister and the Parliamentary Secretary are routinely provided with a copy of each Australian Adverse Drug Reactions Bulletin.

(c) There was no briefing of the Minister's office on the Celebrex adverse effects information prior to the official ministerial announcement of the product's listing on 1 July 2000 in addition to the copy of the June issue of the Australian Adverse Drug Reactions Bulletin on 19 May 2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001, 19/20 February

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E01000179**

Topic: ADVERSE REACTIONS

Written Question on Notice

Senator Evans asked:

In July 2000 an Auditors General's report found that in 1999 the TGA had a backlog of 3325 unprocessed reports of adverse drug reactions:

(a) What steps have been taken to deal with this backlog?

(b) When was the backlog finally cleared?

(c) What steps have been taken to prevent such a backlog occurring again?

(d) What is the current status?

Answer:

(a) Several factors contributed to the backlog, including a loss of data entry staff and a coincident increase in reporting. For the past 12 months, all data entry positions have been occupied and this has enabled the backlog to be cleared.

(b) The Adverse Drug Reactions Unit has established a performance standard that all reports are entered into the database within two weeks of receipt. The backlog was reduced to less than two weeks' reports by the week ending 2 June 2000.

(c) The backlog of reports is monitored weekly and action will be taken if the backlog exceeds the performance standard.

(d) For the week ending 23 February 2001, there were 117 reports awaiting computer entry. All had been received within the previous week.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000104**

Topic: INTERNET AVAILABILITY OF CONTRACEPTIVES

Written Question on Notice

Senator Harradine asked:

An article titled "Internet Availability of Contraceptives" in Obstetrics and Gynaecology, (1/01, pp 121-125) reports that researchers studied 200 websites to locate where birth control pills and other "contraceptive supplies" could be ordered. They were able to "obtain high-dose levonorgestrel pills from Australia for free and with no prescription, but they took up to 18 days to deliver."

(a) What action will the Department take to prevent internet sales of such pills from Australia?

(b) Has the action the Department took against an Australian site which was selling pills over the Net not been effective?

Answer:

(a) The Department has taken action in the past, in conjunction with the relevant State/Territory Health Department/s and the ACCC, to prevent the supply of contraceptive supplies over the Internet. Each organisation has jurisdiction over different aspects of the supply process.

The Department will continue to investigate any reports of sales of contraceptive supplies over the Internet on a case by case basis.

(b) Action taken by the TGA, NSW Health Department and the ACCC has resulted in Telstra closing down the Australian based web-site for CrowdedPlanet. The founder of the site has appeared before the Federal Court, and was subsequently jailed for a two week period for contempt of Court. The NSW Health Department investigations are continuing.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000223**

Topic: Q FEVER

Written Question on Notice

Senator Evans asked:

(a) Which programs are to lose funding in order to meet the $ in unfunded costs for Q fever vaccination?

(b) How have decisions been taken on which areas this money will be targeted?

Answer:

(a) No program will lose funding. The Q Fever vaccination program will be funded from the Regional Health Services Program.

(b) Initial decisions on target groups for the National Q Fever Management Program were made using the best available evidence. This included information on notified national Q fever incidence rates and national Q fever vaccine distribution rates. Further consideration of the scope of this program will be undertaken as a priority task by the Q fever Taskforce.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000152**

Topic: CLINICAL TRIALS

Senator West asked: CA70

Does Australia have a system like Canada does, where there has to be some gender differentiation and mixtures in clinical trials?

Answer:

Applications to the TGA for a new medicine are evaluated for safety, quality and efficacy. In order to demonstrate safety and efficacy, the application must be supported by clinical trials in subjects that represent the intended patient group. Thus, if a medicine were intended for use in the general population, the clinical trials would need to include both male and female subjects that cover a range of ages.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000180**

Topic: VIAGRA

Written Question on Notice

Senator Evans asked:

In August 1998, the Minister announced that he had asked for the drug Viagra to be fast tracked through the TGA's registration system.

(a) Why did that occur and on whose advice did it occur?

(b) Had it happened previously?

(c) Has it happened since?

Answer:

(a) The application to register Viagra was not fast tracked through the TGA registration system. The time required to process an application depends on a number of factors, including the quality of the data submitted and the sponsoring company's preparedness to cooperate and work with the TGA. The application to register Viagra was of a high quality and the sponsoring company's responses were prompt, resulting in a relatively short processing time.

(b) and (c)

Priority evaluation status may be given to an application under the following circumstances:

- the active ingredient is a new chemical entity; and
- the drug is indicated for the treatment or diagnosis of a serious, life-threatening or severely debilitation disease or condition; and
- there is clinical evidence that the drug may provide an important therapeutic gain.

An average of 10 applications per year is granted priority status based on the above criteria.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000181**

Topic: NALTREXONE

Written Question on Notice

Senator Evans asked:

The TGA was sufficiently concerned about the way in which naltrexone was being obtained and used prior to its registration to review and amend the *Therapeutic Goods Act, 1989* last year. Why wasn't this product also fast tracked?

Answer:

The application to register naltrexone tablets (*ReVia*- Orphan Australia Pty Ltd) was granted priority evaluation status by the TGA and was approved for marketing in Australia in January 1999. The allocation of priority evaluation status to an application ensures that the evaluation process will be performed as quickly as practicable. Priority evaluation status may be granted to medicines for the treatment of a serious, life-threatening or severely debilitating disease or condition when there is clinical evidence that the medicine may provide an important therapeutic gain.

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 1: POPULATION HEALTH AND SAFETY **Question: E01000224**

Topic: TOUGH ON DRUGS

Written Question on Notice

Senator Evans asked:

(c) Can the Department provide a full breakdown of the spending commitments made so far against the Tough on Drugs funding and the COAG Diversionary funding showing the amounts spent by program and the commitments in forward years ?

(d) What funds remain uncommitted under the Tough on Drugs and COAG drug programs ?

Answer:

(a) The attached table (Attachment A) provides:

- the total program allocation for each initiative;
- funding expended up to 30 June 2000 for which financial expenditure data is readily available;
- commitments for the current and forward years; and
- uncommitted funds as at March 2001.

(b) Please refer to the answer to (a) above.

Question: E01000224

Attachment A

NATIONAL ILLICIT DRUG STRATEGY AND COAG DIVERSION PROGRAM

Program	Program Allocation	Expenditure up to 30 June 2000	Commitments in current and forward years	Uncommitted
National Illicit Drug Strategy				
NGO Treatment Grants Program	$56.5 million	$18.04 million	$38.44 million	Nil
Community Partnerships Initiative	$8.4 million	$2.49 million	$3.79 million	$2.12 million[1.]
Australian Drug Information Network	$2.33 million	$1.06 million	$1.27 million	Nil
Training Frontline Workers Initiative	$2.8 million	$0.275 million	$1.56 million	$0.965 million[2.]
NHMRC Research	$3.7 million	$0.93 million	$2.7 million	Nil
Treatment Trials (NEPOD)	$1.3 million	$0.867 million	$0.437 million	Nil
Illicits Campaign	$26.5 million	$3.37 million	$16.13 million	$7.0 million[3.]
Best Practice & Evaluation	$4.0 million	$0.460 million	$1.63 million	$1.9 million[2.]
Data Collection	$3.3 million	$1.7 million	$1.6 million	Nil
Australian National Council on Drugs	$2.63 million	$1.31 million	$1.31 million	Nil
COAG Diversion Program and Supporting Initiatives				
Diversion Program	$105 million	$1.5 million	$87.7 million	$15.8 million[4.]
Cannabis Cessation	$1.1 million	Nil	$0.432 million	$0.747 million[2.]
Needle and Syringe Programs (Counsel/Referral)	$30.58 million	$4.69 million	$25.89 million	Nil
Research	$0.252 million	Nil	Nil	$0.252 million[2.]
TOTAL	**$247 million**	**$36 million**	**$183 million**	**$28 million**

Notes:

1. **The remaining funds were allocated for the 2001/02 and 2002/03 financial years.**
2. **Currently subject to contract negotiations or tender processes.**
3. **The first stage of the campaign will be launched in March 2001.**
4. **All States and Territories were advised of their allocation for the Diversion Programme and TAS, NSW, VIC and WA have signed agreements. Negotiations are continuing on the ACT, NT and SA proposals.**

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 2: ACCESS TO MEDICARE **Question: E01000140**

Topic: MEDICARE PAYMENTS TO MIDWIVES

Hansard Page: CA19

Senator Harradine asked:

Why is the department continuing not to recognise the work of midwives [in terms of Medicare payment] and not to recognise the fact that many women prefer midwives to a Doctor?

Answer:

Under the Health Insurance Act 1973, payment of Medicare benefits is restricted to services provided by a registered medical practitioner.

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 2: ACCESS TO MEDICARE **Question: E01000141**

Topic: CLARIFICATION OF MBS DEFINITIONS

Hansard page: CA 21

Senator Harradine asked:

How do you determine what procedures are generally accepted in the medical profession?

Answer:

The Department takes advice from the professional colleges/societies/associations of the medical 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 2: ACCESS TO MEDICARE **Question: E01000142**

Topic: PBAC LEGISLATION/REGULATIONS

Hansard Page: CA 56

Senator Evans asked:

(a) We did not pass the legislation until just before Christmas, was it, as I recall? It was one of the last bills through, I think. When was the legislation passed?

(b) When were the regulations gazetted?

Answer:

(a) The changes to the *National Health Act 1953* in relation to the membership of the Pharmaceutical Benefits Advisory Committee were included as amendments to the National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Bill 2000. That Bill was passed by the Senate on 7 December 2000 and by the House of Representatives the following day. It received Royal Assent on 11 December 2000 (Act No. 146 of 2000).

(b) The related amendments to the *National Health (Pharmaceutical Benefits) Regulations 1960* were made at the Executive Council meeting of 13 December 2000 (Statutory Rules No. 369 of 2000). The regulations were gazetted on 20 December 2000 (see Special Gazette S643 of that 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 2: ACCESS TO MEDICARE **Question: E01000143**

Topic: PBAC NOMINATIONS

Hansard Page: CA 57

Senator Evans asked:

Can you provide us with the information on who the nominating organisation was in each case for those who were selected? I am conscious you were concerned about not providing those who were selected (sic). ***Understood as "…. were not selected".***

Answer:

See the answer to Question E01000225.

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 2: ACCESS TO MEDICARE **Question: E01000144**

Topic: PBAC CONFLICT OF INTEREST PROCEDURE

Hansard Page: CA 57

Senator Evans asked:

I think in that letter the Minister tabled in the House, Senator, there was a fairly good description of that, but we can certainly provide you with a copy of the form letter. We will take that on notice. We do not have it here.

Answer:

A copy of the form letter signed by potential PBAC members to confirm that they have no conflict of interest is attached.

Question: E01000144

Mr Alan Stevens
A/g Assistant Secretary
Pharmaceutical Benefits Branch
Commonwealth Department of Health and Aged Care
GPO Box 9848
CANBERRA ACT 2601

Dear Mr Stevens

I write to confirm that I have no actual or potential conflict of interest in a financial, professional or any other way which would cause embarrassment to the Government should I be offered appointment as a member of the Pharmaceutical Benefits Advisory Committee

I undertake to avoid such conflicts of interest, and in the event that a conflict may arise, to inform the Minister for Health and Aged Care at the earliest opportunity.

Yours sincerely

(Signature)………………………….
(Name)………………………………
January/February 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 2: ACCESS TO MEDICARE **Question: E01000147**

Topic: REMOVAL OF PRODUCTS FROM PBS

Hansard Page: CA 78

Senator Evans asked:

(a) **Could you take that on notice, Mr Stevens, to find the reason why Halotestin was removed?**

(b) **What advice did you receive regarding Halotestin?**

(c) **Did that happen with Halotestin?**

(d) **Are there readily available replacements, similar products, for Halotestin?**

Answer:

(a) Halotestin was removed at the manufacturer's request.

(b) The Department was advised in March 2000 by the manufacturer of Halotestin that, for commercial reasons, it intended to discontinue the supply of this product in Australia. Consequently, the manufacturer requested that the product be removed from the PBS effective 1 November 2000.

(c) Halotestin was deleted from the Schedule of Pharmaceutical Benefits on 1 November 2000.

(d) Halotestin was PBS listed for the treatment of breast cancer. Various other preparations (hormonal and other) remain listed on the PBS for the treatment of breast cancer.

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 2: ACCESS TO MEDICARE **Question: E01000148**

Topic: ZYBAN

Hansard Page: CA 80

Senator Evans asked:

What criteria apply for Zyban? Perhaps you could take it on notice but just give me a general idea of what sort of requirements there are.

Answer:

Zyban is listed as a pharmaceutical benefit for short term use within a comprehensive treatment program. Only one pharmaceutical benefit prescription can be written for a patient for Zyban in any 12 month period. Zyban is also subject to the PBS authority requirements, which means that medical practitioners must obtain oral approval from a Health Insurance Commission officer before writing a pharmaceutical benefit prescription for this medicine.

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 2: ACCESS TO MEDICARE **Question: E01000184**

Topic: ZYBAN - COST

Written Question on Notice

Senator Evans asked:

If the cost of Zyban blows out to more than $20 million in its first year, will the listing have to be reviewed by Cabinet, as is the case with other listing decisions that cost the Government more than $20 million per year?

Answer:

There is a (non legislative) requirement that, if a drug is estimated to cost more than $10 million per annum, it has to be approved by the Prime Minister and Minister for Finance and Administration before listing. They may decide that the listing of the drug should be approved by Cabinet. In the case of Zyban, the estimated annual cost was less than $10 million, so the above approval process was not required.

There is no requirement for the Prime Minister, Minister for Finance and Administration or Cabinet to review all listings whose actual cost is more than $10 million per annum, though the position with the usage of individual drugs may be examined by them from time to time.

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 2: ACCESS TO MEDICATE **Question: E01000185**

Topic: ZYBAN – RELATIONSHIP WITH OTHER 'QUIT' STRATEGIES

Written Question on Notice

Senator Evans asked:

Has the assessment of the listing of Zyban taken into account other possible strategies for assisting smokers to quit – such as Quit counselling and Nicotine Replacement Therapy?

Answer:

The evidence presented to the Pharmaceutical Benefits Advisory Committee (PBAC) indicated that Zyban is more cost effective than nicotine replacement therapy. The Committee did take into account patient counselling in its deliberations. The Pharmaceutical Benefits Scheme (PBS) listing criteria specify that Zyban be used within a comprehensive treatment program, which would include counselling by a general practitioner or Quit counselling.

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 2: ACCESS TO MEDICARE **Question: E01000103**

Topic: MEDICARE STATISTICS ON ABORTION

Written Question on Notice

Senator Harradine asked:

(a) Please provide Medicare statistics on abortion for the last financial year and the seven months since that time, in the more detailed form provided prior to the last less complete set of statistics supplied.

(b) Why is the ACT included with the Northern Territory and New South Wales? Would it be possible for the ACT and each other individual State and Territory to be allocated its own separate number? If not, why not?

Answer:

(a) Tables showing the number of services and benefits paid, by item number and by the State in which the services were rendered in the period 1984/85 to 1999/2000 and the six months to December 1999 and 2000, are attached as Tables 1a, 1b, 1c and 1d.

Tables showing the number of services and benefits paid, by item number and patient State, for the period 1984/85 to 1999/2000 and the six months to December 1999 and 2000, are attached as Tables 2a, 2b, 2c and 2d.

The statistics were derived from quarterly summary files, and accordingly, it was not possible to provide statistics to the end of January 2001.

The definitions of medical services included in the Schedule to the Health Insurance Act which may result in the termination of pregnancy appear in the Medicare Benefits Schedule as follows:

ITEM 16525
MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (effective from 1 November 1995). Prior to 1 November 1995, the relevant item was Item 274/5, 16545/6 - MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction

ITEM 35643
EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 OR 35630 applies, where performed.

The attached data only relates to services rendered on a ‘fee-for-service’ basis for which Medicare benefits were paid. Excluded are details of services to public patients in hospital and through other publicly funded programs.

(b) Medicare data is protected by the secrecy provisions (section 130) of the *Health Insurance Act 1973*, and by the *Privacy Act 1988*. To ensure that there is no inadvertent disclosure of confidential Medicare information, it is the standard practice of the Department of Health and Aged Care, to suppress cells in tables where the number of services is small, or where the number of providers or establishments rendering the items in question is small. This approach has been necessary for Item 16525 (State service rendered and patient State) and Item 35643 (State service rendered) for some States/Territories. Confidential cells are suppressed by either not publishing the cells or by combining cells of data so that totals can be published. This policy is consistent with that followed by the Australian Bureau of Statistics.

Question: E01000103
Table 1a

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 1a: Number of Services Item 16525 (274/5,16545/6)(a), 1984/85 to end Dec 2000, State Service Rendered - Date of Processing

Year	*NSW* (c)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT/NT* (b)	*AUST*
1984/85	167	204	38	76	60	12	15	572
1985/86	184	184	73	78	53	10	21	603
1986/87	185	171	62	61	45	10	21	555
1987/88	204	190	102	72	67	17	22	674
1988/89	222	217	78	65	49	11	18	660
1989/90	223	308	95	45	124	14	31	840
1990/91	264	285	102	62	196	13	29	951
1991/92	266	313	113	60	157	19	22	950
1992/93	256	284	113	82	177	21	25	958
1993/94	261	297	143	63	172	7	26	969
1994/95	240	312	188	61	191	11	29	1032
1995/96	237	223	164	49	119	13	21	826
1996/97	225	172	115	53	62	16	12	655
1997/98	209	164	116	55	63	10	22	639
1998/99	187	158	119	54	48	22	9	597
1999/00	201	208	106	57	46	16	11	645
1999 JUL-DEC	89	82	59	30	29	(d)	(d)	302
2000 JUL-DEC	83	112	57	25	25	(d)	(d)	312

(a) Induction and management of second trimester labour.
(b) Includes data for ACT and NT - not separately available.
(c) Includes a small number of services rendered overseas.
(d) Confidential due to small number of services

Question: E01000103
Table 1b

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 1b: Number of Services Item 35643 (6469)(a), 1984/85 to end Dec 2000,
State Service Rendered - Date of Processing

Year	*NSW* (b)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*AUST*
1984/85	28117	14075	4644	1617	6148	363	85	104	55153
1985/86	29398	14534	4567	1536	6398	436	92	91	57052
1986/87	30375	16349	5159	1638	7011	409	128	96	61165
1987/88	29080	16190	6979	1480	6753	443	118	88	61131
1988/89	28847	17360	8639	1538	7039	365	95	112	63995
1989/90	31355	18895	8688	1620	7422	418	98	144	68640
1990/91	31972	19508	7733	1767	7632	366	97	171	69246
1991/92	33301	19756	9060	1739	7711	614	97	200	72478
1992/93	33029	19857	9969	1176	8078	787	112	266	73274
1993/94	34206	20526	10393	1189	8306	849	108	256	75833
1994/95	34951 (c)	20248	11775	972	8331	754	(d)	186	77217
1995/96	35221 (c)	20118	11756	777	8775	743	(d)	161	77551
1996/97	34407 (c)	20133	11784	632	8383	699	(d)	153	76191
1997/98	33918 (c)	19384	11937	601	8278	639	(d)	157	74914
1998/99	34287 (c)	19379	11908	533	7696	591	(d)	99	74493
1999/00	34131 (c)	18729	12544	580	7124	481	(d)	110	73699
1999 JUL-DEC	16956 (c)	9281	6452	291	3535	259	(d)	58	36832
2000 JUL-DEC	17791 (c)	9387	6510	257	3767	253	(d)	56	38021

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.
(b) Includes a small number of services rendered overseas.
(c) Includes data for ACT. See footnote (d)
(d) Data not available. Included in NSW.

Question: E01000103
Table 1c

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 1c: Benefits Paid Item 16525 (274/5,16545/6)(a), 1984/85 to end Dec 2000,
State Service Rendered - Date of Processing
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Year	*NSW* (c)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT/NT* (b)	*AUST*
1984/85	23328	28406	4673	10954	8251	1536	2074	79222
1985/86	26950	27327	10638	11758	7862	1514	2282	88330
1986/87	26262	24487	8894	8956	6495	1429	3042	79565
1987/88	26044	23978	13047	8912	8436	1750	2890	85054
1988/89	27210	27687	9840	8274	6017	1436	2366	82829
1989/90	29549	40839	12386	6206	15286	1695	4081	110040
1990/91	37398	39736	14060	8954	26207	1866	4217	132438
1991/92	39251	46176	16709	9007	22242	2874	3231	139490
1992/93	39733	44112	17540	12827	25790	3279	3881	147163
1993/94	40913	46654	21885	9985	25418	1105	4071	150031
1994/95	38432	49560	30496	9697	32114	1745	4692	166736
1995/96	38390	36102	27235	7899	20357	2108	3410	135502
1996/97	36584	27908	18646	8631	10118	2627	2001	106515
1997/98	34451	26926	19097	9058	10380	1621	3616	105148
1998/99	31325	26312	19826	9013	8014	3660	1550	99700
1999/00	34027	35365	18029	9654	7765	2712	1864	109416
1999 JUL-DEC	14889	13901	9988	5053	4865	(d)	(d)	50884
2000 JUL-DEC	14162	18939	9792	4300	4288	(d)	(d)	53187

(a) Induction and management of second trimester labour.
(b) Includes data for ACT and NT - not separately available.
(c) Includes a small number of services rendered overseas.
(d) Confidential due to small number of services

Question: E01000103
Table 1d

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 1d: Benefits Paid Item 35643 (6469)(a), 1984/85 to end Dec 2000, State Service Rendered - Date of Processing

Year	*NSW* (b)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*AUST*
1984/85	2983968	1481716	492474	162710	654638	34664	8168	10415	5828753
1985/86	3241794	1586504	502184	162064	708062	45341	9076	9545	6264570
1986/87	3210170	1713654	543101	167630	743451	41115	12849	9935	6441906
1987/88	3011061	1662215	729780	135446	704960	40912	10508	8160	6303043
1988/89	3073975	1833065	933946	141997	757682	33498	8194	10356	6792712
1989/90	3537717	2105921	991065	159014	847090	39430	9374	14271	7703882
1990/91	3790067	2287863	919920	182339	915962	36252	9461	18136	8159999
1991/92	4079041	2377944	1108347	186401	954765	68703	9951	21941	8807095
1992/93	4117395	2458153	1261425	128715	1031763	94662	11816	29524	9133454
1993/94	4207953	2581966	1335344	131644	1077729	105692	11327	29384	9481040
1994/95	4382311 (c)	2577686	1527164	110044	1093690	95249	(d)	21683	9807828
1995/96	4498206 (c)	2591740	1551337	88903	1170550	94849	(d)	18572	10014157
1996/97	4426255 (c)	2611460	1563180	72324	1124500	89035	(d)	17522	9904276
1997/98	4426325 (c)	2546568	1598043	69991	1123577	83238	(d)	18597	9866339
1998/99	4566754 (c)	2568566	1622204	63685	1060561	77984	(d)	11595	9971349
1999/00	4630501 (c)	2465059	1741477	69283	996291	64397	(d)	13245	9980252
1999 JUL-DEC	2287505 (c)	1221850	889921	34659	491831	34444	(d)	7206	4967416
2000 JUL-DEC	2441002 (c)	1230617	912237	31088	531511	33963	(d)	6874	5187293

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.
(b) Includes a small number of services rendered overseas.
(c) Includes data for the ACT. See footnote (d).
(d) Data not available. Included in NSW.

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 2a: Number of Services Item 16525 (274/5,16545/6)(a), 1984/85 to end Dec 2000, Patient State - Date of Processing

Year	*NSW*	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT/NT*	*AUST*
1984/85	168	204	40	75	60	12	13	572
1985/86	183	184	76	78	53	10	19	603
1986/87	186	172	63	60	46	9	19	555
1987/88	210	187	100	72	68	17	20	674
1988/89	223	216	77	64	50	12	18	660
1989/90	228	303	96	45	124	15	29	840
1990/91	273	279	102	59	194	15	29	951
1991/92	273	308	115	58	154	21	21	950
1992/93	265	282	115	80	172	22	22	958
1993/94	274	284	141	64	172	9	25	969
1994/95	233	304	193	62	192	(b)	(b)	1032
1995/96	237	227	161	49	118	(b)	(b)	826
1996/97	230	171	113	52	62	(b)	(b)	655
1997/98	212	162	117	55	63	(b)	(b)	639
1998/99	188	157	118	54	48	(b)	(b)	597
1999/00	210	196	108	57	46	(b)	(b)	645
1999 JUL-DEC	89	80	61	30	29	(b)	(b)	302
2000 JUL-DEC	87	106	57	25	25	(b)	(b)	312

(a) Induction and management of second trimester labour .
(b) Confidential due to small number of services

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 2b: Number of Services Item 35643 (6469)(a), 1984/85 to end Dec 2000, Patient State - Date of Processing

Year	*NSW* (b)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*AUST*
1984/85	24435	13495	7460	1682	6090	746	1069	176	55153
1985/86	25173	13967	7841	1642	6329	829	1099	172	57052
1986/87	26353	15803	8208	1764	6857	780	1213	187	61165
1987/88	26315	15682	8596	1618	6702	783	1256	179	61131
1988/89	26865	16901	9449	1711	6967	727	1189	186	63995
1989/90	28136	18582	10451	1830	7384	751	1275	231	68640
1990/91	27997	18978	10421	1892	7624	814	1283	237	69246
1991/92	29296	19418	11540	1897	7703	972	1369	283	72478
1992/93	29521	19610	12180	1337	8061	993	1262	310	73274
1993/94	30516	20137	12756	1425	8290	1038	1330	341	75833
1994/95	31179	19923	13918	1203	8324	983	1395	292	77217
1995/96	31595	19786	13684	1004	8710	1035	1498	239	77551
1996/97	30983	19800	13652	839	8323	900	1435	259	76191
1997/98	30857	19074	13556	790	8195	872	1339	230	74914
1998/99	31049	19057	13771	700	7684	768	1284	180	74493
1999/00	30989	18420	14305	746	7081	665	1300	193	73699
1999 JUL-DEC	15375	9124	7360	381	3495	346	655	96	36832
2000 JUL-DEC	16003	9247	7489	345	3774	329	731	103	38021

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.
(b) Includes a small number of services for which patient State was unknown.

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 2c: Benefits Paid Item 16525 (274/5,16545/6)(a), 1984/85 to end Dec 2000, Patient State - Date of Processing

Year	*NSW*	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT/NT*	*AUST*
1984/85	23486	28406	4953	10808	8251	1536	1782	79222
1985/86	26824	27307	11088	11758	7862	1514	1978	88330
1986/87	26545	24619	9004	8814	6606	1318	2659	79565
1987/88	26838	23595	12763	8912	8563	1750	2635	85054
1988/89	27357	27499	9747	8141	6150	1570	2366	82829
1989/90	30397	40179	12510	6206	15113	1834	3802	110040
1990/91	38773	38825	14060	8502	25951	2145	4183	132438
1991/92	40238	45428	17010	8706	21815	3182	3112	139490
1992/93	41130	43781	17841	12501	25124	3426	3360	147163
1993/94	42910	44605	21622	10143	25446	1406	3900	150031
1994/95	37167	48284	31356	9854	32312	(b)	(b)	166736
1995/96	38359	36843	26708	7899	20147	(b)	(b)	135502
1996/97	37398	27745	18320	8468	10118	(b)	(b)	106515
1997/98	34945	26597	19259	9058	10380	(b)	(b)	105148
1998/99	31493	26144	19658	9013	8014	(b)	(b)	99700
1999/00	35560	33325	18365	9654	7765	(b)	(b)	109416
1999 JUL-DEC	14889	13565	10324	5053	4865	(b)	(b)	50884
2000 JUL-DEC	14867	17950	9792	4300	4288	(b)	(b)	53187

(a) Induction and management of second trimester labour.
(b) Confidential due to small number of services

COMMONWEALTH DEPARTMENT OF HEALTH AND AGED CARE
Table 2d: Benefits Paid Item 35643 (6469)(a), 1984/85 to end Dec 2000, Patient State - Date of Processing

Year	*NSW* (b)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*AUST*
1984/85	2587355	1419215	795723	170068	648234	75948	114145	18065	5828753
1985/86	2769598	1523480	868042	173849	700326	89074	121710	18493	6264570
1986/87	2780192	1655575	868960	181331	726934	80692	128752	19469	6441906
1987/88	2717677	1608335	900223	150806	699465	77137	131758	17643	6303043
1988/89	2857674	1782336	1021722	161585	749477	73265	128188	18465	6792712
1989/90	3163555	2069703	1196267	183905	842143	77990	146119	24198	7703882
1990/91	3306524	2222832	1246338	198424	914694	90832	154237	26118	8159999
1991/92	3576244	2335627	1419307	207293	953237	113265	169976	32145	8807095
1992/93	3674754	2425260	1539222	149566	1029034	121072	159263	35282	9133454
1993/94	3759423	2528622	1619606	162315	1074995	130215	165680	40185	9481040
1994/95	3894286	2532943	1806277	140289	1091942	125305	181243	35542	9807828
1995/96	4015774	2545966	1809947	119216	1160747	133948	199524	29035	10014157
1996/97	3966485	2565474	1816401	100057	1115480	116197	192425	31757	9904276
1997/98	4010964	2503390	1819236	95378	1111663	114795	182268	28644	9866339
1998/99	4119844	2524413	1880877	86457	1058121	102266	176597	22774	9971349
1999/00	4187783	2425032	1989656	92107	989407	89803	181770	24694	9980252
1999 JUL-DEC	2065578	1201658	1017414	47033	485863	46372	90919	12580	4967416
2000 JUL-DEC	2186201	1212757	1051247	43421	532080	44452	103674	13461	5187293

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.
(b) Includes a very small number of services for which patient State was unknown.

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 2: ACCESS TO MEDICARE **Question: E01000105**

Topic: PSYCHOLOGICAL SERVICES

Written Question on Notice

Senator Harradine asked:

According to mental health experts, depression is now the fourth biggest health problem in Australia. Has the Department given any consideration to having psychological services covered by Medicare?

Answer:

Under current health insurance legislation, Medicare benefits arrangements are designed to provide assistance to people who incur medical expenses in respect of clinically relevant professional services that are contained in the Medicare Benefits Schedule and rendered by qualified medical practitioners. In this regard mental health services provided by medical practitioners are covered under Medicare. However services provided by allied health professionals such as psychologists are not included under the Medicare arrangements.

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 2: ACCESS TO MEDICARE **Question: E01000225**

Topic: PBAC APPOINTMENTS

Written Question on Notice

Senator Evans asked:

(a) Can you provide a full list of the people appointed, under which section they were appointed and who the nominating organisation was in each case.

(b) Can you provide CV's for each of the new members?

Answer:

(a) All members have been appointed under subsection 100(B)1 of the National Health Act 1953. The full list of people appointed and the nominating organisations are set out below.

Name (Position)	Nominating Organisation
Professor Lloyd Sansom (Chairman)	Ministerial Appointee
Mr Neil Anderson (Member)	Pharmacy Guild of Australia
Mr Matthew Blackmore (Member)	Consumers Health Forum
Professor Terry Campbell (Member)	Royal Australasian College of Physicians
Professor Robert Carter (Member)	Economic Society of Australia
Mr Patrick Clear (Member)	Ministerial Appointee
Associate Professor Andrea Mant (Member)	Royal Australian College of General Practitioners; Committee of Presidents of Medical Colleges.
Professor John Alasdair Millar (Member)	Royal Australasian College of Physicians
Dr Stephen Phillips (Member)	Australian Medical Association Ltd
Dr Anne Tonkin (Member)	Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists
Professor David Wilkinson (Member)	Royal Australian College of General Practitioners
Associate Professor Robyn Ward (Member)	Ministerial Appointee

(b) A copy of their CVs are attached. Purely personal information contained in each CV has been deleted. **[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 2: ACCESS TO MEDICARE **Question: E01000226**

Topic: PHARMACEUTICAL INDUSTRY LIAISON

Written Question on Notice

Senator Evans asked:

(a) On how many occasions in the last year have departmental officers attended functions, dinners or travel paid for by the pharmaceutical industry or a particular company?

(b) What are the arrangements for declaration of such matters?

Answer:

(a) In the period 19 February 2000 - 23 February 2001 there were 13 occasions on which departmental officers attended functions or dinners paid for by the pharmaceutical industry or a particular pharmaceutical company. Over this period there was one occasion where the travel expenses of a departmental officer were paid for by a particular pharmaceutical company, to attend the Rural Directions in Psychiatry conference sponsored by Eli Lilly Australia Pty Ltd under the auspices of the Royal Australian and New Zealand College of Psychiatrists.

(b) The acceptance of hospitality by departmental officials is governed by the Public Service Commission (PSC) Guidelines on Official Conduct of Commonwealth Public Servants and the Department of Health and Aged Care's *Gifts and Benefits Guidelines*. In general, staff may accept hospitality benefits of an inconsequential or trivial nature where there is no real or apparent conflict of interest, or where refusal may give offence. Where staff have any doubts, they are required to seek advice from the Branch Assistant Secretary or Divisional First Assistant Secretary or equivalent. In all cases in (a), such advice was sought and approval given.

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 2: ACCESS TO MEDICARE **Question: E01000227**

Topic: BENELONG GROUP

Written Question on Notice

Senator Evans asked:

(a) Can the Department provide the minute of 14th November on the meeting between the Prime Minister and the Benelong Group, which was forwarded to the Parliamentary Secretary?

(b) Was this Minute forwarded to the Minister for Health and Aged Care?

Answer:

(a) No, as it was not prepared by this Department. The Department of Prime Minister and Cabinet would be the appropriate agency to consider this request.

(b) See answer to (a) 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 2: ACCESS TO MEDICARE **Question: E01000146**

Topic: NOTE RECEIVED BY DEPARTMENT FOLLOWING PM's MEETING WITH PHARMACEUTICAL MANUFACTURERS ON 10/11/00

Hansard Page: CA 76, 77

Senator Evans asked:

(a) Will you take that question on notice for me, please, as to whether or not it was copied to the Minister as well.

(b) I should formally ask, are you prepared to make the note available to the committee?

Answer:

(a) and (b) see answer to question E01000227.

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 2: ACCESS TO MEDICARE **Question: E01000228**

Topic: CONSUMER HEALTH FORUM

Written Question on Notice

Senator Evans asked:

(a) What are the performance requirements for the Consumers' Health Forum to maintain Government funding?

(b) Are there any requirements for the Forum to provide appointments to Government regulatory committees?

(c) Was there any discussion at a Departmental or Ministerial level about the discontinuation of funding of Consumers' Health Forum if it did not cooperate by making a nomination to the new PBAC?

(d) Dr Wooldridge is quoted in the Financial Review of the 9/2/01 as stating that the 'relationship between PBAC and industry had become unnecessarily adversarial to the point where it was counterproductive.' Who had it become counterproductive to – How was it counterproductive to the taxpayer?

(e) Are committee members personally liable if the PBAC decision is taken to court? What protection do the members have?

Answer:

(a) The Consumers' Health forum (CHF) receives national secretariat funding under the Community Sector Support Scheme (CSSS). Funding to national secretariats provided under the CSSS is tied to the achievement of annually negotiated outputs in the areas of policy, representation, information dissemination and governance.

(b) There is no such requirement under the CSSS Funding agreement.

(c) The Department is not aware of any such discussion about this matter in relation to CSSS funding, nor to other funding provided from time to time to conduct research on specific consumer related health issues.

(d) The development of an unnecessarily adversarial relationship between PBAC and industry is counterproductive to the core objective of the Pharmaceutical Benefits Scheme of achieving for all Australians timely, reliable and affordable access to necessary and cost effective prescription medicines.

(e) PBAC members are not personally liable if a PBAC decision is subject to legal challenge. Whilst carrying out PBAC duties, members are afforded the same legal indemnity as public servants.

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 2: ACCESS TO MEDICARE **Question: E01000229**

Topic: OLD COMMITTEE MEMBERS

Written Question on Notice

Senator Evans asked:

(a) How many and who of the old Committee members were approached to serve on the new PBAC?

(b) Which Committee members refused to serve on the committee with an industry representative?

Answer:

(a) and (b)

As indicated by Mr Podger at the Senate Estimates discussions on 19 February 2001, it is not considered to be appropriate for the Department to respond to these questions.

The Department points out that there is no industry representative on the PBAC.

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 2: ACCESS TO MEDICARE **Question: E01000230**

Topic: PBAC COMMITTEE ROLE IN RECOMMENDING PRICE

Written Question on Notice

Senator Evans asked:

(a) How can a Committee that is legally required to take account of economic factors including cost effectiveness for a drug before it recommends listings not make price recommendations?

(b) Is the Celebrex listing the first time the Pricing Authority has not taken the PBAC's recommendations on price and conditions (that the drug be listed with a price volume agreement)?

(c) Why did the Pricing Authority ignore PBAC's recommendation that the drug only be listed at a price of a $1 a day with a price volume agreement?

(d) Was legal advice obtained to ascertain whether the Pricing Authority could ignore the price and conditions recommended by the PBAC? If so what did this legal advice conclude and who requested it?

(e) If the PBAC has no role in recommending price – how does it fulfil its obligations under the National Health Act to consider price. Isn't making price recommendations central to the PBAC's decision to list a new drug?

Answer:

(a) The Pharmaceutical Benefits Advisory Committee (PBAC) makes recommendations to the Government on the listing of medications on the Pharmaceutical Benefits Scheme (PBS). It is the role of the Pharmaceutical Benefits Pricing Authority (PBPA) to recommend prices. As part of its process, the PBAC provides advice on clinical effectiveness and cost-effectiveness and this advice is taken into account by the PBPA. The PBAC's advice on cost-effectiveness takes the sponsoring company's proposed listing price as its base.

(b) The PBAC's advice is taken into account by the PBPA in recommending an appropriate price for listing. The pricing arrangement for Celebrex recommended by the PBPA and agreed to by the Minister for Health and Aged Care does include the introduction of a price/volume agreement as one of its components.

It is not, however, the PBAC's role to recommend price.

(c) The PBPA did not ignore the PBAC's recommendation in relation to Celebrex. It took this advice into account along with other factors. As listed in its Annual Report, there is a range of factors that the PBPA is able to take into account when recommending an appropriate listing price.

(d) The advice was obtained from the Legal Affairs Branch of the Department in relation to whether the Minister could determine a pricing arrangement for Vioxx similar to that for Celebrex, notwithstanding the conditions relating to price set out in the PBAC's recommendation to list Vioxx. The advice was requested by officers of the Pharmaceutical Benefits Branch of the Department and it concluded that the Minister was not bound by the pricing conditions that the PBAC applied in relation to its recommendations to list Vioxx.

(e) Under the *National Health Act 1953*, it is the role of the PBAC to consider cost and effectiveness. It does this by considering the sponsoring company's application which includes a proposed listing price. From this the PBAC can advise on estimated total cost and cost-effectiveness.

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 2: ACCESS TO MEDICARE **Question: E01000231**

Topic: PBPA

Written Question on Notice

Senator Evans asked:

(a) Who were the members of the PBPA when it recommended to the Minister that Celebrex should be listed at $1.17 a day with no price/volume agreement?

(b) What checks were made of conflicts of interest for each of the members of the PBPA?

(c) What are the procedures at the PBPA for declaration of conflicts of interest?

(d) Have of the members of the PBPA received funding from any pharmaceutical companies. For example costs to attend a conference or subsidise part of a member's salary?

(e) Does the Department continue to make sure that the members of the Pricing Authority do not have a conflict of interest, how is this done?

Answer:

(a) The pricing of Celebrex was considered at the Pharmaceutical Benefits Pricing Authority (PBPA) meeting of 12 April 2000. Members of the PBPA present at that meeting were Messrs Graham Glenn (Chairman), Alan Evans (Australian Pharmaceutical Manufacturers Association), Geoff Honnor (Consumers Health Forum), Brett Lennon (Department of Health and Aged Care) and Craig Pennifold (Department of Science, Industry and Resources)

(b) No conflict of interest was declared by any member of the PBPA at the meeting of 12 April 2000.

(c) In accordance with PBPA Guidelines, members of the PBPA are required to declare any instance where s/he, a partner/family member or close family friend has a direct financial or other interest which influences, or may appear to influence, the proper consideration of a submission before the Authority.

(d) No member of the PBPA has declared receipt of funding from any pharmaceutical manufacturers. Obviously, Mr Evans' salary is indirectly funded by pharmaceutical manufacturers in that he is the Chief Executive Officer of their representative body, the Australian Pharmaceutical Manufacturers Association.

(e) Yes. The requirement to declare any conflict of interest or potential conflict of interest is a standing item on the agenda for each meeting of the Pricing Authority. In addition, members are also required to make an annual declaration of pecuniary and other potential conflicts of interest.

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 2: ACCESS TO MEDICARE **Question: E01000232**

Topic: LAUNCH OF THE PFIZER PRODUCT ARICEPT

Written Question on Notice

Senator Evans asked:

(a) Is it true that the Minister attended a launch of the Pfizer product Aricept on the PBS just before Christmas 2000?

(b) Was the Launch organised by the Alzheimers Association in Hawthorn, Melbourne?

(c) Whose idea was it to launch the drugs listing on the PBS - the Minister's, Pfizer's or the Alzheimer's association?

(d) Who approached the Minister to attend the launch - Pfizer or the Alzheimer's Association?

(e) Who paid for the launch - Pfizer or the Alzheimer's Association?

(f) Did the Department meet any costs on its own behalf or on behalf of the Minister?

(g) Who attended the Launch with the Minister (how many personal staff and how many departmental staff)?

Answer:

(a) to (e) The Department has no details of this.

(f) No

(g) No Departmental officers attended.

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 2: ACCESS TO MEDICARE **Question: E01000176**

Topic: CELECOXIB (CELEBREX) SALES BLOWOUT

Written Question on Notice

Senator Evans asked:

(a) Do the revised estimates for Celebrex take into account the February listing of Vioxx? If not, why not and if so, how much of the additional cost can be attributed to the listing of a second drug in this class?

(b) Can you provide copies of the data on which the original estimates of demand were based?

(c) In the past year in cases where the sponsoring pharmaceutical company has provided market data, how often have they underestimated the size of the market?

(d) In the Minister's press release he announced that half a million people would benefit from Celebrex. How many people have actually been given a prescription and how many people have received multiple prescriptions?

(e) What action is being taken to address the massive cost blowout associated with the listing of Celebrex and Vioxx?

Answer:

(a) When the estimates of Celebrex were revised, account was taken of the listing of Vioxx. Vioxx is an alternative product and it is expected that it will take some market share away from Celebrex. The addition of Vioxx, the second drug in the class, is expected to add approximately $9 million to the cost of the Pharmaceutical Benefits Scheme (PBS).

(b) A table of the demand and cost estimates of Celebrex at the time it was approved by Cabinet for listing on the PBS is set out hereunder:

Celecoxib data	**2000/2001 $**	**2001/2002 $**	**2002/2003 $**	**2003/2004 $**
Total PBS prescriptions	1,105,000	1,417,500	1,799,460	1,871,438
60 x 100mg strength - 40%				
- General (35%)	1,821,330	2,458,796	3,121,343	3,246,197
- Concessional (52%)	6,484,296	8,753,800	11,112,601	11,557,105
- Safety Net (13%)	1,801,254	2,431,693	3,086,938	3,210,415
60 x 200mg strength – 60%				
- General (35%)	9,040,500	12,204,675	15,493,351	16,113,085
- Concessional (52%)	19,099,080	25,783,758	32,731,458	34,040,716
- Safety Net (13%)	5,045,040	6,810,804	8,646,045	8,991,887
Total cost of Celecoxib	43,291,500	58,443,525	74,191,736	77,159,405
Less NSAID* prescriptions	682,500	921,375	1,169,649	1,216,435
- Concessional (80%)	4,864,860	6,567,561	8,337,258	8,670,748
- Safety Net (20%)	1,666,665	2,249,998	2,856,283	2,970,534
Total cost of NSAIDs	6,531,525	8,817,559	11,193,541	11,641,283
Net cost of Celecoxib	36,759,975	49,625,966	62,998,195	65,518,123

* Non Steroidal Anti- Inflammatory Drugs

(c) Out of the 28 new chemical entities listed on the PBS during the period November 1999 to November 2000, 16 underestimated the size of the market and 12 overestimated the size of the market.

(d) Information is not available on the number of individuals that have actually received a prescription. However, between the time the drug was listed on 1 August 2000 and the end of January 2001, nearly 2 million prescriptions were processed – 64% original prescriptions and 36% repeat prescriptions.

(e) At the time of revising the estimates for Celebrex, the companies sponsoring the products were asked to submit data to the PBAC for review. This review will occur at the PBAC meeting in 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 2: ACCESS TO MEDICARE **Question: E01000182**

Topic: VIAGRA PBAC APPLICATION

Written Question on Notice

Senator Evans asked:

(a) When was the first PBAC application for Viagra rejected?

(b) When was the second PBAC application for Viagra rejected?

Answer:

(a) The first application for listing Viagra on the PBS was rejected by the PBAC in December 1998.

(b) The second application for listing Viagra was rejected by the PBAC in June 1999.

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 2: ACCESS TO MEDICARE **Question: E01000183**

Topic: VIAGRA AND DISMISSAL OF PBAC SECRETARY

Written Question on Notice

Senator Evans asked:

(a) When was Mr Des Threlfall removed from his position as Secretary of the PBAC?

(b) Was Mr Threlfall removed from his position at the Minister's request?

(c) If so, was it due to his handling of the Viagra application. If not, why was he removed?

Answer:

(a) Mr Threlfall transferred from his position as Secretary to the Pharmaceutical Benefits Advisory Committee to the position of Pharmaceutical Adviser to the Pharmaceutical Benefits Branch in September 1999.

(b) No.

(c) The transfer was part of a reorganisation within the Pharmaceutical Benefits Branch.

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 2: ACCESS TO MEDICARE **Question: E01000186**

Topic: MODIFIED CLAWBACK

Written Question on Notice

Senator Evans asked:

Where is the Government's specific commitment on the Modified Clawback written down? Can a copy be provided?

Answer:

As part of introducing the Lifetime Health Cover provisions in September 1999 the Government made a commitment that no State or Territory would lose revenue under the claw back arrangements in the Australian Health Care Agreements (AHCAs).

On 23 September 1999, Senator Lees, Leader of the Australian Democrats, tabled a letter from Dr Wooldridge, Minister for Health and Aged Care, outlining this commitment. A copy of that letter is attached.

In November 2000 the Government decided to modify this arrangement to exclude revenue received by public hospitals for the treatment of entitled veterans from the calculations. This modification was conveyed orally to State and Territory officers at a meeting on 19 October 2000. The Commonwealth is working with the States and Territories to a variation to the AHCAs to incorporate the revised arrangements.

The Hon Dr Michael Wooldridge
Minister for Health and Aged Care

22 September 1999

Senator Meg Lees
Leader of the Australian Democrats
Parliament House
CANBERRA ACT 2600

Dear Meg,

Just to confirm our conversation this morning. The Government is willing to give the following undertakings on lifetime health cover:

1. We guarantee that, over the life of the current Health Care Agreement (1988-2003), no State or Territory will be worse off as a result of the claw back provisions in the Health Care Agreements. I have detailed how this would work on a separate attachment.

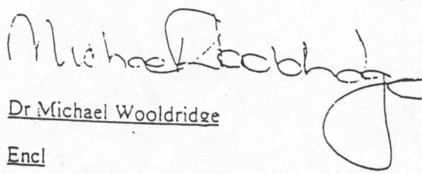
2. I will regulate so that products with front end deductibles over $500 will not satisfy an exclusion from the Medicare Surcharge Levy from 1 July 2000. People would still be free to purchase products with high front end deductibles, it just would not exclude them from the levy surcharge. Thus, a low income person, not subject to the surcharge who wishes to buy a very cheap product, would still be able to do so.

3. Refugees will be able to lock into a base premium rate within twelve months of first becoming eligible for Medicare.

4. I share your concerns on known gaps or informed financial consent. I will undertake to prepare a brochure detailing patients' rights in this matter and have this available in all Medicare offices in Australia within two months. I am happy to keep you involved as the production of this occurs. I concede this is a first step and am happy to monitor its effect with you.

5. I agree with the advertising issues raised by the Democrats in their Minority Report. My Chief of Staff will write a separate letter agreeing that print advertising for life time health cover will address these issues.

Yours sincerely,



Dr Michael Wooldridge

Encl

22 SEP 1999

Suite MG 48 Parliament House Canberra ACT 2600 Telephone (02) 6277 7220 Facsimile (02) 6273 4146

Amendments agreed to by the Government and the Democrats on Lifetime Health Cover

Public hospitals

The Democrats were concerned that any sudden rise in the rate of private health insurance participation rates would leave public hospitals worse off. Under the Australian Health Care Agreements between the Commonwealth and the States/Territories signed last year, the Commonwealth and the States/Territories share the risk of a change in private health insurance coverage.

Should participation rates fall below a certain level (differing between States and Territories, but averaging around 29%), then the Commonwealth provides an additional $82 million to the States and Territories for their public hospital system for each percentage point decrease. Conversely, should participation rates rise above a certain level (averaging around 33%), Commonwealth grants would be reduced by $82 million for each percentage point increase.

The private health insurance participation rate in the June quarter was 30.5%.

This risk sharing arrangement is in the context of the biggest ever rise in Commonwealth funding for public health systems, an increase of more than 20% in real terms to more than $30,600,000,000.

The Democrats concern was that any increase in private health insurance participation rates would penalise the States and Territories.

The Government has agreed to a new proposal which would alleviate these concerns, in effect guaranteeing that the States and Territories can not be worse off as a result of any increase in private health insurance participation rates.

The Commonwealth will offer each State and Territory a deal in the event that private health insurance participation rates rise above the level where Commonwealth grants would be reduced. Revenue from privately insured patients and veterans will be compared to revenue received from these patients during 1997-98.

Should the increase in revenue from privately insured patients and veterans in public hospitals not match or exceed any loss in revenue from the Commonwealth under the Australian Health Care Agreements, the Commonwealth will waive the additional reduction.

So, for example, if a State's grant would otherwise be reduced by $7 million, and the increase in revenue received by that State in that year was $5 million more than in 1997/98, the Commonwealth would waive $2 million. Therefore, the State would not be any worse off as a result of the increase in private health insurance participation.

Should that State receive an additional $9 million in private patient and veteran revenue, the State would be better off as a result of the increase in private health insurance participation.

This deal will protect the States and Territories and provide stability in income for the public hospital system.

Information for patients on 'the gap'

The Government and the Australian Democrats are concerned about the issue of gaps for private patients. As a first step, the Government has agreed to better inform consumers about the gap and the rights of patients.

The Government's policy is to promote informed financial consent. That is, should the patient be liable for any payment above the Medicare Schedule fee, then the doctor should inform the patient of this prior to the consultation or procedure.

This is also consistent with current Australian Medical Association (AMA) policy.

As a first step, the Government will produce a brochure to be available in all Medicare outlets and for mailing out with statements, that will detail the Government's policy on informed financial consent and inform patients of their rights.

Concessions for refugees

New refugees entering Australia will have an opportunity to lock in a base rate of premium should they join private health insurance within twelve months of becoming eligible for Medicare.

Front end deductible products and the Medicare levy surcharge

The Government will introduce regulations which will limit the use of excessive front end deductible products from eligibility for exemption from the Medicare Levy Surcharge for high income earners.

Products with a front end deductible in excess of $500 will not be eligible for exemption from the surcharge from 1 July 2000.

Advertising campaign

The Government has agreed to meet Australian Democrats concerns regarding the print and Internet advertising campaign due to accompany the introduction of Lifetime Health Cover.

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 2: ACCESS TO MEDICARE **Question: E01000187**

Topic: ASSIGNMENT OF PIP

Written Question on Notice

Senator Evans asked:

(a) Is the Department aware of the practice of doctors being required to apply for grants from the Department and to pass such grants on to corporate employers of a doctor?

(b) Are such practices legal?

Answer:

(a) It is the general practice, rather than individual doctors, that applies for the Practice Incentives Program (PIP). As part of the application process, individual doctors working in the practice are required to give consent for Medicare and Department of Veterans' Affairs data to be used in assessing the practice's payment entitlement under PIP. However, it is the practice not the individual doctor that receives PIP payments.

(b) Distribution of PIP payments is a matter for the practice and employee doctor concerned. It is legal for a practice to allocate PIP funds to an employee doctor as part of an employment contract or to withhold them.

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 2: ACCESS TO MEDICARE **Question: E01000188**

Topic: ASSIGNMENT OF PIP

Written Question on Notice

Senator Evans asked:

(a) Are payments under the Practice Incentives Program personal payments to a doctor or are they payable to a corporate entity, which employs doctors?

(b) Is it legal for such payments to be assigned as part of an employment contract?

Answer:

(a) Payments under the Practice Incentives Program (PIP) are not personal payments to doctors. PIP payments are made to eligible general practices. In some instances, it may be a corporate entity that owns the general practice and is the recipient of the PIP payment.

(b) See answer to question E01000187.

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 2: ACCESS TO MEDICARE **Question: E01000189**

Topic: COMPLEX DELIVERY ITEM

Written Question on Notice

Senator Evans asked:

(a) In answer to E035 you have given figures for the average gap for three MBS items concerning labour and delivery. These are figures for private health insurance only and show the gap as the difference between the fee charged and the Schedule fee. Could you also provide the same data for uninsured patients giving the gap between the fee charged and the Medicare rebate?

(b) Could you also provide the total number of services reimbursed for each item number for insured and uninsured patients showing the number of services bulk billed?

(c) Could you also provide the total amount paid out to doctors for each item number of services bulk billed?

(d) Is it not correct that the introduction of the new item number 16522 in 1998 has no discernible effect on growth in gap fees?

(e) Although the new fee was some $300 higher than the old fee the average gap has dropped by less than $85 and the average gap fee rose by more than 15% in its first year. What has the Department done to control the rise in this gap charge?

(f) What research has the Department done to establish the causes of these high costs and to revise the policy to one that achieves the objectives of Medicare for expectant mothers?

(g) What has been the total increase in Government spending as a result of this measure and what benefits has it delivered for the public?

Answer:

(a) Insured and uninsured patients cannot be differentiated in Medicare data. The data provided in Question E035 was an estimate of the average out-of-pocket expenses that privately insured patients incur under the new complex delivery item assuming that the insurance fund covers the cost between the rebate and the schedule fee.

Question: E01000189

The following Table shows the average difference between the fees charged and the Medicare rebate:

MBS Item	Description	Average fee charged less benefits paid		
		1997/98	**1998/99**	**1999/00**
16519	Management of labour and delivery (standard)	$376.87	$404.15	$446.09
16520	Caesarean section where the patient's care has been transferred to another practitioner for the management of the confinement	$292.77	$294.48	$325.70
16522	Management of labour and delivery (complex)	N/A	$456.69	$497.83

(b) This data is not available. As noted above, insured and uninsured patients cannot be differentiated in Medicare data.

(c) The following Table lists the amounts paid by item for services that were bulk billed for the period from the first quarter1997-98 to the second quarter2000-01.

MBS Item No	1997-98		1998-99		1999-2000		2000-01*	
	Number of services bulk billed	Benefits paid for bulk billed services	Number of services bulk billed	Benefits paid for bulk billed services	Number of services bulk billed	Benefits paid for bulk billed services	Number of services bulk billed	Benefits paid for bulk billed services
16519	178	$56,527	101	$32,339	151	$47,891	51	$16,454
16520	2	$687	3	$791	-	$ -	3	$1,080
16522	N/A	N/A	21**	$15,877**	43	$31,940	16	$23,880
Total	180	$57,214	125	$49,007	194	$79,831	70	$41,414

***   Figures are for the first and second quarters only for 2000-01***

***** Figures for item 19522 are from the second quarter for the year 1998-99***

(d) The overall gap (defined as the difference from fee charged to schedule fee as in response to question E035) fell slightly between 1997-98 and 1998-99, but rose again between 1998-99 and 1999-2000.

(e) The introduction of private health insurance reforms such as no/known gaps schemes and informed financial consent are designed to control the rise in gap payments.

(f) The Department has held discussions with the National Association of Obstetricians and Gynaecologists and the Royal Australian College of Gynaecologists on a number of obstetric/gynaecological issues, including the effect of the introduction of item number 16522. Discussions in this regard are continuing.

(g) The total increase in government spending from the third quarter 1999 until June 2000, was approximately $11m. This is shown in the table below:

Year	**Increase**
1998/99	$3,644,672
1999/00	$7, 267,255
Total	**$10,911,927**

Women continue to be provided with high quality medical care at a reasonable cost to the Government.

National Health (Pharmaceutical Benefits) Amendment Regulations 2000 (No. 1)[1]

Statutory Rules 2000 No. 369[2]

I, WILLIAM PATRICK DEANE, Governor-General of the Commonwealth of Australia, acting with the advice of the Federal Executive Council, make the following Regulations under the *National Health Act 1953*.

Dated 13 December 2000

WILLIAM DEANE
Governor-General

By His Excellency's Command

MICHAEL WOOLDRIDGE
Minister for Health and Aged Care

1 Name of Regulations

These Regulations are the *National Health (Pharmaceutical Benefits) Amendment Regulations 2000 (No. 1).*

2 Commencement

These Regulations commence on the commencement of Schedule 2 to the *National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Act 2000*.

3 Amendment of *National Health (Pharmaceutical Benefits) Regulations 1960*

Schedule 1 amends the *National Health (Pharmaceutical Benefits) Regulations 1960*.

Schedule 1 Amendments

(regulation 3)

[1] Regulation 38, definition of *Committee*

omit

section 101

insert

section 100A

[2] After regulation 38

insert

38A Appointments to Committee — nominating bodies (Act s 100B (1A))

(1) For paragraph 100B (1A) (a) of the Act, the following consumer organisations are prescribed:

(a) the Consumers' Health Forum of Australia;

(b) the Australian Federation of AIDS Organisations;

(c) the Australian Consumers' Association.

(2) For paragraph 100B (1A) (b) of the Act, the following professional associations of economists are prescribed:

(a) the Australian Health Economics Society Inc;

(b) the Economic Society of Australia Inc.

(3) For paragraph 100B (1A) (c) of the Act, the following professional associations of pharmacists are prescribed:

(a) the Pharmacy Guild of Australia;

(b) the Pharmaceutical Society of Australia;

(c) the Society of Hospital Pharmacists of Australia.

(4) For paragraph 100B (1A) (d) of the Act, the following professional associations of medical practitioners are prescribed:

(a) the Australian Medical Association Limited;

(b) the Royal Australian College of General Practitioners;

(c) the Australian Divisions of General Practice Limited;

(d) the Doctors Reform Society — Australia Inc;

(e) the Australian Federation of Medical Women Inc.

(5) For paragraph 100B (1A) (e) of the Act, the following professional associations of clinical pharmacologists are prescribed:

(a) the Royal Australasian College of Physicians;

(b) the Australasian Society of Clinical and Experimental Pharmacologists and Toxicologists.

(6) For paragraph 100B (1A) (f) of the Act, the following professional associations of specialists are prescribed:

(a) the Australian Medical Association Limited;

(b) the Royal Australasian College of Physicians;

(c) the Committee of Presidents of Medical Colleges.

38B Number of nominations for appointment (Act s 100B (1B))

For subsection 100B (1B) of the Act, each body prescribed for subsection 100B (1A) of the Act must be asked to nominate at least 3 persons for selection for appointment as members of the Committee.

[3] Regulation 40

substitute

40 Resignation

(1) The Chairperson of the Committee may resign as Chairperson by notice in writing given to the Minister.

(2) A member of the Committee may resign from the Committee by notice in writing given to the Minister.

[4] Regulation 48

omit

Notes

1. These Regulations amend Statutory Rules 1960 No. 17, as amended by 1960 Nos. 90 and 102; 1961 Nos. 59 and 137; 1962 Nos. 34, 101 and 114; 1963 Nos. 34, 69 and 107; 1964 Nos. 12, 57 and 135; 1965 Nos. 51, 151 and 152; 1966 Nos. 80 and 144; 1967 Nos. 67, 116 and 158; 1968 Nos. 44, 76, 88 and 146; 1969 Nos. 44, 107 and 185; 1970 Nos. 39, 94, 119 and 186; 1971 Nos. 44, 101, 136 and 154; 1972 Nos. 32, 121 and 205; 1973 Nos. 15, 57, 139 and 229; 1974 Nos. 37, 126 and 222; 1975 Nos. 50, 148 and 209; 1976 Nos. 84, 150, 195 and 255; 1977 Nos. 39, 125 and 221; 1978 Nos. 47, 142, 153 and 245; 1979 Nos. 51, 55, 144 and 250; 1980 Nos. 69, 213 and 338; 1981 Nos. 52, 212, 218 and 345; 1982 Nos. 69, 76, 179, 334 and 372; 1983 Nos. 28, 102, 116 and 292; 1984 Nos. 50, 148, 169 and 342; 1985 Nos. 32, 184 and 320; 1986 Nos. 38, 194, 319, 320 and 391; 1987 Nos. 47, 262 and 279; 1988 No. 56; 1990 Nos. 226, 267, 337, 338 and 437; 1991 Nos. 1 and 474; 1992 No. 226; 1994 No. 348, 1996 No. 70; 1998 No. 374.
2. Notified in the *Commonwealth of Australia Gazette* on 20 December 2000.