Community Affairs
Legislation Committee

Examination of Budget Estimates 2005-2006

Additional Information Received

VOLUME 7

HEALTH AND AGEING PORTFOLIO

Outcomes 7, 8, 9, 10, 11

FEBRUARY 2006

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.

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2005-2006

Included in this volume are answers to written questions on notice and tabled papers relating to the budget estimates supplementary hearing on 2 November 2005

HEALTH AND AGEING PORTFOLIO

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-032

OUTCOME 7: Indigenous Health

Topic: TJUNGUNGKU KURANYUKUTU PALYANTJAKU (TKP)

Written Question on Notice

Senator Evans asked:

(a) List the dates and locations of TKP meetings held since 1 April 2005?
(b) Are the minutes of these meetings publicly available? The minutes of the 1/04/05 Meeting of the TKP are on the internet.

Answer:

(a) The Tjungungku Kuranyukutu Palyantjaku (TKP) has met three times since 1 April 2005:
- 2 May 2005 in Adelaide
- 25 – 27 July 2005 in Alice Springs
- 10 – 11 November 2005 in Adelaide.

(b) Minutes of the 2 May 2005 meeting are not yet publicly available on the Waru website www.waru.org. It is anticipated the minutes of the 2 May 2005 will be available shortly. The 25 – 27 July 2005 minutes should also be available shortly given they were endorsed at the 10 – 11 November 2005 meeting. The November meeting minutes will not be available until endorsement at the next TKP meeting scheduled in February 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-033

OUTCOME 7: Indigenous Health

Topic: TJUNGUNGKU KURANYUKUTU PALYANTJAKU (TKP)

Written Question on Notice

Senator Evans asked:

Was a regional partnership agreement (RPA) discussed at the July meeting? When is the signing of the RPA expected to take place? What things need to be done before the RPA can be reached?

Answer:

Yes, a Regional Partnership Agreement (RPA) framework was discussed at the TKP meeting on 25- 27 July 2005. It was agreed that further development of an RPA will be pursued following implementation of the Work Plan undertaken by the newly appointed Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands) Services Coordinator.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-034

OUTCOME 7: Indigenous Health

Topic: TJUNGUNGKU KURANYUKUTU PALYANTJAKU (TKP)

Written Question on Notice

Senator Evans asked:

Were "milestones" discussed at the July TKP meeting? Were any milestones set? What were they?

Answer:

Milestones were developed for the Anangu Pitjantjatjara Yankunytjatjara Lands (APY Lands) Services Coordinator Work Plan to address key priorities at the 25 – 27 July 2005 Tjungungku Kuranyukutu Palyantjaku (TKP) meeting.

Milestones and their anticipated timeframes included:

- brokering a location for the Substance Misuse Facility (high priority);
- determining effectiveness of policing services and night patrol (to be assessed in early 2006);
- investigating and mapping an educational pathway for Anangu students (to be assessed in early 2006); and
- mapping employment and training needs across the APY Lands to contribute to the development of a regional workforce strategy (to be assessed early in 2006).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-035

OUTCOME 7: Indigenous Health

Topic: TJUNGUNGKU KURANYUKUTU PALYANTJAKU (TKP)

Written Question on Notice

Senator Evans asked:

Confirm that part of the TKP's role is to monitor and report on progress and provide feedback on current policy?

Answer:

The Terms of Reference for Tjungungku Kuranyukutu Palyantjaku (TKP) include getting better results through improved services for Anangu through shared responsibility for policy development and reporting on progress and results.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-036

OUTCOME 7: Indigenous Health

Topic: TJUNGUNGKU KURANYUKUTU PALYANTJAKU (TKP)

Written Question on Notice

Senator Evans asked:

Who finances administration costs of the TKP Regional Forum?

Answer:

Administration costs for the Tjungungku Kuranyukutu Palyantjaku (TKP) Regional Forum are financed by the Department of Health and Ageing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-037

OUTCOME 7: Indigenous Health

Topic: TJUNGUNGKU KURANYUKUTU PALYANTJAKU (TKP)

Written Question on Notice

Senator Evans asked:

The minutes of the April 2005 meeting of the TKP indicate the Anangu Taskforce requested a funded secretariat for the TKP that was independent of Government. Has this been agreed to? Has the secretariat been established? What is the timeframe for establishing one?

Answer:

At the 1 April 2005 meeting of the Tjungungku Kuranyukutu Palyantjaku (TKP), a consensus was reached that funding options would be explored for a secretariat to support the Anangu Wiru Palyantjaku Taskforce. This secretariat support would:

- be independent of Government, with the position based on the AP Lands;
- assist in organising meetings, travel arrangements and accommodation for the Wiru Palyantjaku Taskforce; and
- act as a conduit of information dissemination for the TKP.

Funding has since been secured from the Office of Indigenous Policy Coordination. The filling of this position will occur in February 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-038

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

What is the Department's reason for their decision to not roll-out OPAL universally through the Central Desert Region?

Answer:

While it is feasible to provide regional coverage in remote areas, it is far less practical within large townships such as Alice Springs. It is not possible to completely eradicate sniffable fuel from large regional markets. For example, aircraft require aviation fuel, for which there is currently no non-sniffable substitute fuel. Similarly, premium unleaded fuel, which stands beside regular fuel bowsers, will still be required. There are more than ten service stations in Alice Springs, each of which has existing agreements with suppliers. All of these also supply premium unleaded fuel, for which there is no "non-sniffable" substitute.

An Opal petrol outlet is planned for Alice Springs. This will make the non-sniffable fuel available to both locals and tourists travelling into the central desert region. Consultations are currently taking place between service station operators in Alice Springs and the fuel industry to identify a suitable outlet.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-039

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

Has the Department conducted any estimates on how much it would cost to do a universal roll-out of OPAL fuel in the central desert region? What are they?

Answer:

The department, in consultation with British Petroleum, conducted a preliminary estimate in August 2005. The estimated cost to the department for a universal roll-out of Opal in the central desert region defined by the government, as well as one outlet in Alice Springs, is at least $10,560,000 per annum.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-040

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

Is the Department aware of the NT Coroner's estimates? ($8 million p/a) How does that compare with the Department's estimate?

Answer:

Yes, the department is aware of Coroner Cavanagh's quote of estimates which were provided to him by Mr Greg Andrews, Manager, Mutitjulu "Working Together" Project.

Mr Andrews did not define the region on which he based his estimates of $8 million per annum subsidy. Assuming the area is the same as the Australian Government's defined central desert region of central Australia, plus one outlet in Alice Springs, then the department's estimate is over $2 million per annum more than Mr Andrew's estimate.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-041

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

What is the process for determining which communities should get OPAL? Does this involve an assessment of need?

Answer:

The Comgas Scheme was originally developed for individual remote Aboriginal and Torres Strait Islander communities and registration was gained through an application process. Applications were processed by order of date received. The growing demand and shift to regional approaches now renders this approach unsuitable.

The method by which communities and regions access the program is currently being redeveloped to take into account prevalence of petrol sniffing, proximity to sources of sniffable fuel, and community commitment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-042

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

Is the Department aware that Papunya has a high number of petrol sniffers? Does Papunya have OPAL fuel? If not, why not?

Answer:

The Papunya Community was registered onto the Comgas Scheme in May 2004. The first delivery of Opal fuel was in June 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-043

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

Has Papunya applied for OPAL fuel? If so, when did they apply? If their application was rejected, what was the reason?

Answer:

The Papunya Community was registered on the Comgas Scheme in May 2004. The first delivery of Opal fuel was in June 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-044

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

Can the Department confirm that Haasts Bluff applied for OPAL? If so, when? Has their application been considered? If their application was rejected, what was the reason?

Answer:

The Ikuntji Community of Haasts Bluff applied for registration to the Comgas Scheme, now known as the Petrol Sniffing Prevention Program, on 9 May 2005. The Ikuntji Community was registered on the Comgas Scheme on 16 September 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-045

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

What do communities need to do to apply for OPAL? What is the process?

Answer:

The Comgas Scheme was originally developed for individual communities and access was gained through an application process. It involved community completion and lodgment of a one-page registration form accompanied by a covering letter signed by an authorised community representative to confirm that the proposal to join the Scheme was supported by the whole community and that the community either had in place or planned to implement complementary diversionary and/or prevention strategies such as sport, music, bush craft, employment or education. Applications were processed by order of date received.

The growing demand and shift to regional approaches now renders this process unsuitable. The method by which communities and regions access the program is currently being redeveloped to take into account prevalence of petrol sniffing, proximity to sources of sniffable fuel and community commitment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-046

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

a) How many communities now have OPAL fuel?

b) Can the Department provide a list of the communities which will not get OPAL fuel but have indicated to the Department that they want it?

Answer:

a) Forty communities are currently receiving regular deliveries of Opal fuel.

b) There are no remote Aboriginal and Torres Strait Islander communities that have applied for the Comgas Scheme and been refused. Applications from three communities are currently being considered.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-047

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

On the 12 September 2005 SA, WA, NT and Federal Governments signed off on an 8-point plan to combat petrol sniffing. The Northern Territory News reported that the plan "involves consistent laws across the NT, SA and WA, zero tolerance for traffickers, further roll-out of non-sniffable petrol, activities for young people, treatment facilities, communication and education, and strengthening and supporting communities."

a) Please attach a copy of the plan?
b) Is the document of the plan publicly available? If not, why not?
c) Please set out the details of the plan? Who is responsible for each element?
d) Does it set out time frames for implementation?
e) How much new funding is connected to the plan?
f) Is this plan connected with the COAG "whole-of-government" Structure? How?

Answer:

a) See Attachment A.

b) No. The plan is an evolving document and is still being finalised with the jurisdictions involved.

c) The Western Australian, Northern Territory and South Australian Governments have given their support to the draft eight point plan of action developed by the Australian Government to combat petrol sniffing in Central Australia. Each stakeholder will have differing but complementary responsibilities for implementation of particular activities. Specific responsibilities will be spelt out in Shared Responsibility Agreements with each affected Aboriginal and Torres Strait Islander community and reinforced through the development of Regional Partnership Agreements where necessary.

d) No. However, given the complexity of the issues being addressed, the central desert strategy will need to be in place for a number of years.

e) Australian Government funding of $9.5 million is attached to the eight point plan to combat petrol sniffing in the designated central desert region of central Australia.

f) Yes, this is a whole of government strategy which fits with the principles of the Council of Australian Governments' agreement.

The South Australian and Australian Government agencies involved in the strategy are already participants for the COAG trial site in the Anangu Pitjantjatjara (AP) lands.

THE PROPOSED STRATEGY FOR ADDRESSING PETROL SNIFFING IN CENTRAL AUSTRALIA

Background

Petrol sniffing in the central Australia region transcends state and territory borders and is not something that the Australian Government can address by itself. However, the new arrangements in Indigenous Affairs provide an excellent basis on which to work, in conjunction with the Northern Territory (NT), South Australian (SA) and Western Australian (WA) Governments, and communities, to develop and implement a comprehensive strategy to address petrol sniffing across a significant part of the central desert region.

Extent of the Problem

The extent of the petrol sniffing problem in Indigenous communities is not known with any certainty. There is no consistent reliable data on the numbers who sniff petrol. In 1992 Maggie Brady estimated that there were between 600 and 1000 chronic sniffers in SA, WA and NT.[1] In 2004 the Northern Territory Department of Health and Community Services estimated between 260-355 petrol sniffers in NT and the tri-state region.[2] A survey of petrol sniffing in Anangu Pitjantjatjara Lands in 2004 found that 8.4% (222) of the total population (2500) were categorised as petrol sniffers (either experimental, occasional or chronic).[3] An evaluation of the Comgas scheme in 2004 reported that the level of petrol sniffing had declined over the past 20 years (by estimating the numbers of people then sniffing as compared to data collected by Brady).

It is difficult to accurately predict the numbers of petrol sniffers or any trends in sniffing because it is episodic in nature and varies in and between communities. However, the behaviour of petrol sniffers and the long term effects on habitual sniffers has a disproportionately negative effect on the community. According to one coronial submission, petrol sniffing is associated with increased violence, acquired brain injury, property damage, child abuse and neglect, dispossession of Elders and theft.

Australian Government response to date

Since 1998 the Government has had measures in place to address petrol sniffing in Indigenous communities. The Comgas scheme has provided subsidised non-sniffable fuel to 37 registered Indigenous communities. In recognition that reduction of supply is not the sole answer to this issue, the scheme also provides for community based diversion initiatives. In the 2005-06 budget the Government increased its spending to $13.6 million over the next four years (2005-06 to 2008-09) to extend the scheme to 65 communities and to include piloting a regional approach in two COAG trial sites.

There are also a range of other programs both mainstream and Indigenous-specific which can have an impact on petrol sniffing.

---

1 Brady, M. (1992) *Heavy Metal: The Social Meaning of Petrol Sniffing in Australia*

2 *Petrol Sniffing in Remote Northern Territory Communities (2004)*: Evidence to the Legislative Assembly of the Northern Territory Select Committee on Substance Abuse in the Community, p17.

3 Estimate by Nganampa Health (2004)

New Developments
With the development of a new unleaded non-sniffable fuel (Opal) from February 2005, and the recent deaths attributed to petrol sniffing in both SA and the NT, there is an impetus for a renewed effort to address the problem. Opal reportedly has more support in Indigenous communities than the previous fuel (Avgas) because it is unleaded and can be used in motor vehicles and motor boats without damage to their engines.

The Government accepts the need to roll-out Opal more widely in the central deserts region but also emphasises that it is a complex problem which requires a holistic and strategic response. It is working with the SA, NT and WA governments on a strategy to address petrol sniffing in the central Australia region. A regional approach is being adopted to acknowledge both the high level of need and the ease with which the 'substance' can be transported/trafficked. A key part of the strategy needs to involve stamping out trafficking so that communities have a chance to get on top of this issue.

While Governments can work together to produce a holistic strategy, they cannot effectively address the issue without commitment from the communities involved. A review of petrol sniffing interventions in Aboriginal communities concluded that the most successful strategies are initiated by the community, enjoy widespread community support and involve strong participation of community members.[4]

Regional strategy to address petrol sniffing
The focus of public debate has been on rolling out of Opal. A regional strategy will need to do much more than a greater roll-out of Opal in the area. The Australian Government is looking to roll-out Opal in an area of the central desert that covers southern NT, the AP lands and a small part of WA. But this alone will not fix the problem. It will need a comprehensive strategy including measures which between them address prevention, early intervention and treatment and rehabilitation.

The goals of the strategy are to:
- reduce the incidence and impact of petrol sniffing in a defined area of central Australia; and
- evaluate the effectiveness of this regional and holistic response to petrol sniffing to determine whether, and if so how, it might usefully be expanded to other regions with similar issues.

Elements of the strategy

In our view, an effective strategy needs the following eight elements:

1. **A rollout of Opal fuel** to affected communities, roadhouses and pastoral properties in the targeted area
2. **A uniform legal framework** across the region dealing with:
    - petrol sniffing and mental health
3. **Appropriate levels of policing**
    - including a permanent presence to support the community

4 D'Abbs P & Maclean S (2000) *Petrol Sniffing in Aboriginal Communities: A Review of Interventions*

4. **Alternative activities** for people in the area

- Education/land management/CDEP/jobs/etc
- Requires a focus on providing activities for all people in the area – not just the sniffers

5. Rehabilitation and treatment facilities

- Treatment facilities for sniffers with Acquired Brain Injury
- Respite for families/supported accommodation for sniffers
- Support services – eg safe houses

6. Communication strategy

- Using a population health approach – with messages that are designed carefully to avoid adverse affects
- Health promotion/Drug education

7. Strengthening and supporting communities

- Place managers/youth workers/sport and recreation officers
- Workforce strategy (over time) to grow local people into local jobs and ensure that, in the meantime, we have qualified professionals to assist
- Other capacity building activities

8. Evaluation

- The strategy needs a strong focus on evaluation so that we know whether this approach is working

Alice Springs
Alice Springs
Walungurru
Lake Macdonald
Papunya
Haasts Bluff
Hermannsburg
Areyonga
MACDONNELL RANGES
Harts Range
Santa Teresa
SIMPSON DESERT
Hay
River
Sandy
Warakurna-Giles
Docker River
PETERMANN RANGE
Yulara
Curtin Springs Roadhouse
Lake Amadeus
Mount Ebenezer Roadhouse
Kulgera Roadhouse
Erldunda Roadhouse
Finke
River
Amata
MUSGRAVE RANGES
Aparawatatja
Kiwirrkura
Maria
Adminga
Macumba
Warburton
Creek
SERT
RIA DESERT

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-048

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Evans asked:

Given that there are 600 petrol sniffers located in the central desert region, does the COAG trial include a health-specific strategy to target petrol sniffing on A-P lands? If so what are the details of this strategy? If so, what funding has been allocated for this strategy?

Answer:

A Shared Responsibility Agreement (SRA) drafted in the first year of the COAG trial had the improvement of the health and well being of Anangu as one of its priorities. This included responding to the problem of substance misuse. The SRA was not signed by all parties.

This issue is now being addressed through the recently announced regional strategy to combat petrol sniffing in the cross border region.

The Western Australian, Northern Territory and South Australian governments have given their support to the draft 8-point plan of action developed by the Australian Government to combat petrol sniffing. This whole-of-government initiative will tackle petrol sniffing through consistent legislation, appropriate levels of policing, a further roll-out of non-sniffable fuel, alternative activities for young people, treatment and respite facilities, communication and education strategies, strengthening and supporting communities, and evaluation.

Australian Government funding of $9.5 million is attached to the 8-point plan to combat petrol sniffing in the designated central desert region of central Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-050

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING EXPENDITURE

Written Question on Notice

Senator Evans asked:

How much of this budget measure has been expended to date? Please specify the programs/areas that have received these funds?

Answer:

No funding under this budget measure has been expended to date. It is expected that the 2005-06 appropriation will be fully expended by the end of the financial year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-051

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING EXPENDITURE

Written Question on Notice

Senator Evans asked:

In September this year, the Department announced a further $9.5 million boost to petrol sniffing funding.
(a) Please provide a specific breakdown of these funds according to program activity.
(b) Please provide a specific breakdown according to departmental costs and administered expenditure. Please identify the amount of departmental costs also included in administered expenditure.

Answer:

On 12 September 2005 a further $9.5 million to boost Australian Government petrol sniffing funding for the central desert region of central Australia was announced by the Minister for Health and Ageing and the Minister for Immigration, Multicultural and Indigenous Affairs.

Of this amount, $6 million is to be made available to the Department of Health and Ageing and the distribution of these funds between administered and departmental expenditure is provided in the table below.

Funding	**2005-2006**	**2006-2007**	**Total**
Administered	2,633,000	2,524,000	5,157,000
Departmental	374,000	481,000	854,000
Health Total	**3,007,000**	**3,005,000**	**6,011,000**

It is proposed that an additional six remote Aboriginal and Torres Strait Islander communities, seven roadhouses and up to nine pastoral properties will be added to the Comgas Scheme under this allocation.

There are no departmental costs included in administered expenditure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-052

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING EXPENDITURE

Written Question on Notice

Senator Evans asked:

Has the Department done any estimate on the health care cost to the Commonwealth of petrol sniffing:
(c) In Central Australian region?
(d) In the Anangu-Pitjantjarra COAG trial site?
(e) Throughout Australia?
What were these estimates?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-053

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING EXPENDITURE

Written Question on Notice

Senator Evans asked:

How much does the Department currently spend on health and social services targeting petrol sniffing?

Answer:

Estimated expenditure for the period 2005-06 to 2008-09:

Funding	2005/06	2006/07	2007/08	2008/09
Department Total $	**6,334,030**	**6,240,666**	**3,853,333**	**3,836,000**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-054

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING EXPENDITURE

Written Question on Notice

Senator Evans asked:

In relation to the Petrol Sniffing Diversion Pilot Project: Can you confirm that in 2004-05, $381,668 was spent under this program? Can you confirm that in 2005-06, $316,666 was allocated under the budget? Why were funds reduced by $65,000?

Answer:

Final expenditure on this project was $381,668 for 2004-05 and is projected to be $316,666 for 2005-06. The project budget was negotiated between the Department of Health and Ageing and the service provider based on the needs of the project.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-055

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

In a QON from last estimates it was revealed that $1,087,886.63 was spent on the trial to date. It stated $602,367.65 of that sum was administered funds and $485,518.98 was departmental costs. Explain why the departmental costs were so high?

Answer:

Departmental costs for the COAG trial are used to fund salary and other costs of field officers employed to work on the COAG trial, as well as support staff in Central Office. There has been a particular focus on improving the way government agencies work with each other and with communities. As a result, considerable investment of departmental staff time and resources has been required.

The department has two field officers employed to work on the COAG trial, based in Adelaide. One of these officers (Executive level 1) devotes 100% of time to the COAG trial and the second allocates 50% of time to the COAG trial. In addition, staff in national office provide support to field officers.

The costs included in departmental expenditure for 2003-04 and 2004-05 included expenditures for the two field officers, as well as estimated expenditure for staff in Central Office who have a role in supporting the trial.

The estimated 2003-04 and 2004-05 administered funds figure of $602,367.65 (previously provided in June 2005 QoN E05-156) has been revised to $1,036,560 to include some items of funding that were excluded from the previous answer in error (see November 2005 answer E05-056 for details).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 2 November 2005

Question: E05-000056

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

It was also asked by QON in the last estimates to "provide details of expenditure by activity for the 2003-4 and 2004-05 financial years for the COAG trial". The answer to this question was missing [Question: E05-156]. Provide these details now, including both administered and departmental lines of expenditure.

Answer:

The Department of Health and Ageing expenditure details by activity for the 2003-04 and 2004-05 financial years for the AP Lands COAG trial:

Administered Funds

Activity	**2003-04 $ (GST incl)**	**2004-05 $ (GST incl)**
Contractor	84,160	
COAG miscellaneous (eg workshops, catering, TKP Secretariat support etc)	36,703	30,309
Consultant	24,632	113,386
Mai Wiru (Regional Healthy Stores Policy)	99,000	319,706
Anangu Pitjantjatjara Inc. (Rural Transactions Centre Submission)	57,200	
P Y Media	196,027	75,437
Total	**497,722**	**538,838**

Departmental Funds

2003-04 $203,164 **2004-05** 282,353

The estimated 2003-04 and 2004-05 administered funds figure of $602,367.65 (previously provided in June 2005 QON E05-156) has been revised to $1,036,560 to include some items of funding that were excluded from the previous answer in error.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-059

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

Has the Department identified performance indicators for the trial? If so, when were they set? What are they? When will they be reported on? If not, when will they be set? What is the reason for the delay?

Answer:

There are no specific performance indicators for the trial. There is, however, an agreement to work on the five regional priorities that were identified in the draft Shared Responsibility Agreement which were:

- Improving the health and wellbeing of Anangu by:
  - implementing responses by all of the partners to the problem of substance misuse, and
  - improving availability and affordability of healthy food supplies.
- Improving educational attainment, training opportunities, employment opportunities and career pathways, especially for younger Anangu.
- **Improving access for Anangu to a wide range of social and community services by developing the infrastructure for regional delivery of basic services such as banking and financial facilities, postal and telecommunications services, and a range of Commonwealth government services eg Centrelink, Medicare easy claim, Job Network.**
- Improving physical infrastructure, especially the quality, reliability and affordability of essential services, the maintenance and upgrade of roads, air and other public transport and appropriately designed, constructed and maintained community housing.
- **Supporting and strengthening existing regional governance structures.**

There are no reports on performance indicators for the COAG trial. The COAG trials are based on a set of general objectives which include better coordination of programs and services, and the tailoring of government programs and services to the needs of communities.

Given the nature of these objectives, a set of specific performance indicators (such as those used to evaluate traditional government programs) is not appropriate for measuring the trial's effectiveness. Measurement of progress will need to be largely qualitative, and is best addressed through the evaluation process now in train. Existing government programs within the trial site continue to have their own performance indicators which reflect the aims of these programs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-060

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

Has any formal or informal evaluation of the trial been conducted? If so, provide a copy of any related documentation? If not, when will an evaluation be conducted? Will this information be publicly available?

Answer:

All evaluations are being undertaken externally. The Office of Indigenous Policy Coordination is managing the evaluation of the AP Lands COAG trial in collaboration with other Government agencies, State and Territory Governments and the Indigenous communities involved.

The Commonwealth has taken a two stage approach to evaluation of the COAG trials, with evaluations of all trial sites being undertaken in 2005-06 and again in 2007-08.

The first stage evaluations are now underway and will be completed in early 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-062

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARA COAG TRIAL

Written Question on Notice

Senator Evans asked:

Provide the number and percentage of Indigenous staff in the Department at present. In general and working specifically on the COAG trial. How does this compare to the number of Indigenous staff in 2004? And 2003?

Answer:

As at 30 June 2005 the Department of Health and Ageing (the Department) employed 83 staff who identified as Aboriginal or Torres Strait Islander people. This is 1.96% of the total Departmental staff. The number of staff who identified as Aboriginal or Torres Strait Islander people as at 30 June 2004 was 89 (2.16%) and as at 30 June 2003 it was 79 (1.93%).

The Department currently has 1.5 FTE (full-time equivalent) staff working exclusively on the Anangu-Pitjantjantjara COAG trial. One of these officers (1 FTE or 67%) is an Indigenous Australian. There were no officers who identified as Aboriginal or Torres Strait Islander people working on the Anangu-Pitjantjantjara COAG trial as at 30 June 2004 or 30 June 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-063

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH DATA

Written Question on Notice

Senator Evans asked:

a) Does the Department have adequate baseline data to start track Indigenous health outcomes?
b) Has the Department done any assessment of need on a regional basis? Provide a list of these assessments?
c) Does the Department have statistics on a disaggregated, local and regional basis? Please name the assessments that have provided this disaggregated information.

Answer:

a) In part. There is a range of data available on health outcomes such as life expectancy, mortality, hospitalisation, survey data on health status etc but the problems with the identification of Indigenous Australians within many of these datasets limits our ability to identify clear trends. Where there are data of sufficient quality, some improvements in Indigenous health have been observed, for example, declines in mortality in Western Australia between 1991 and 2002.

b) Regional planning was a requirement for all State and Territory jurisdictions in the initial stages of the implementation of the Primary Health Care Access Program (PHCAP). Regional plans developed by PHCAP partnership forums in each jurisdiction compared need across local regions and identified gaps in, and priorities for, primary health care service provision to local Indigenous communities.

The following is a list of the completed regional plans:

- South Australian Aboriginal Health Regional Plans
- Queensland Aboriginal and Torres Strait Islander Health Partnership Aboriginal and Torres Strait Islander Health Profiles
- Central Australian Health Planning Study (Northern Territory)
- Top End Aboriginal Health Planning Study (Northern Territory)
- New South Wales Aboriginal Health Regional Plans
- Victorian Koori State Health Plan
- West Australian Regional Aboriginal Health Plans
- Tasmanian Aboriginal Health Plans

c) Given the small size of the Indigenous population and problems with the accurate identification of Indigenous Australians within administrative datasets such as mortality and hospitalisation, there is only limited accurate data available at the regional level. The Census collects data that is available at the regional level on the demographic profile of the Indigenous population. The Community Housing and Infrastructure Needs Survey collects community level data on housing and infrastructure and access to health services and schools. Research projects provide data on specific regions. Work is currently underway to investigate what additional data could be used at the regional level eg perinatal data, Australian Childhood Immunisation Register data, mortality in certain areas and survey data with samples sizes large enough for some regional analysis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-064

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH DATA

Written Question on Notice

Senator Evans asked:

Is the Department tracking its performance in closing the gap in health according to statistical evidence? How is it doing this?

Answer:

Yes. The Aboriginal and Torres Strait Islander Health Performance Framework is being developed to track the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health. The Strategic Framework recognises that a comprehensive and coordinated effort both across and beyond the health sector is required to address the complex and inter-related factors that contribute to the current health outcomes. In addition to a responsive health system, action in areas such as education, employment, transport and nutrition is also required if sustainable health gains are to be achieved. The Health Performance Framework will measure trends in health outcomes, determinants of health and health system performance. It will include measures which relate to the work of this department in providing access to mainstream and Indigenous-specific health programs. The first report against the Health Performance Framework will be published in late 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-065

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH OUTCOMES

Written Question on Notice

Senator Evans asked:

Has the Department set any targets for improved Indigenous health outcomes?

Answer:

For Indigenous health generally, targets are not in place. The Aboriginal and Torres Strait Islander Health Performance Framework will provide baseline data that could be used to set targets in the future. The first report against the Framework will be published in late 2006.

The Healthy for Life Program has targets for improved Indigenous health related to that program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-066

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

Can you provide a brief description of the elements of the trial your Department is leading? What specific initiatives are being implemented?

Answer:

The Tjungungku Kuranyukutu Palyantjaku (TKP) regional forum provides governance for the COAG trial and other whole of government activity on the Anangu-Pitjantatjarra Lands (AP Lands). The TKP consists of representatives from Anangu regional services providers, the Australian Government and the South Australian Government.

The TKP is focused on achieving better results and improved services for Anangu through shared responsibility for:

- policy development;
- service planning and coordination (including priorities, gaps, barriers and opportunities);
- reporting on progress and results; and
- working towards the establishment of a Regional Partnership Agreement reflecting the needs and aspirations of all the partners.

Two COAG-endorsed projects are being progressed on this site:

- Implementation of stage three of the Regional Stores Policy, which focuses on improving the availability and affordability of health food supplies; and
- PY Ku Network, which aims to improve access to a wide range of social and community services on the AP Lands through infrastructure development across seven communities in the AP Lands.

Both projects also aim to improve training and employment opportunities.

A number of other whole of government projects to address regional priorities such as employment and training opportunities, strengthening families and increasing safety are also currently under development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-061

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

Has the Department reported to OIPC or the secretaries group on the progress of the trial? List the dates of reporting. Provide copies of any reports.

Answer:

The Department has provided input to the Office of Indigenous Policy Coordination on the AP Lands COAG trial in April 2005 and June 2004. This was for reports being prepared for COAG and we are therefore awaiting advice from the Department of Prime Minister and Cabinet as to whether this input may be made publicly available.

Monthly meetings of the Secretaries' Group on Indigenous Affairs generally include an update of the COAG trials and the Secretary of the Department of Health and Ageing provides verbal reports as required. Recent meetings of the Secretaries' Group were held on:

- 8 November 2005
- 6 October 2005
- 6 September 2005
- 2 August 2005
- 6 June 2005
- 3 May 2005
- 1 March 2005
- 1 February 2005

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-071

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

Have you reported to OIPC or the secretaries group on the progress of the trial? List the dates of reporting. We request that you attach any reports.

Answer:

Please refer to E05-061.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-067

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

(a) How much has your department spent on the COAG trial to date?
(b) Can you provide a specific breakdown of these funds, including administered funds, and departmental costs?
(c) How much is allocated this year? Can you provide a specific breakdown of these funds according to administered and departmental expenses?

Answer:

(a) $1,522,077 of Department of Health and Ageing funding has been spent on the AP Lands COAG trial as at 30 June 2005. This comprises $1,036,560 Administered funding and $485,517 Departmental funding.

(b) A specific breakdown on expenditure by the Department of Health and Ageing on the COAG trial to date, and estimated for 2005-06, is as follows:

Activity	**Expenditure 2003-04 $ (GST incl)**	**Expenditure 2004-05 $ (GST incl)**	**Estimated Expenditure 2005-06 $ (GST incl)**
Administered Funds	497,722	538,838	873,701
Departmental Funds*	203,164	282,353	154,000
Total	**700,886**	**821,191**	**1,027,701**

*Departmental funds expenditure is for those officers working exclusively on the Anangu-Pitjantjantjara COAG trial and an estimate of additional time contributed by other officers.

The estimated 2003-04 and 2004-05 administered funds figure of $602,367.65 (previously provided in June 2005 QoN E05-156) has been revised to $1,036,560 to include some items of funding that were excluded from the previous answer in error (see November 2005 answer E05-056 for details).

(c) The Department of Health and Ageing has allocated $1,027,701 to the COAG trial in 2005-06. A specific breakdown of these funds is included in the table above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-068

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

Has your department identified a baseline data (e.g. school attendance figures, incidence of disease, etc) for use in measuring the success of the trial? When was this dataset formally agreed on?
If not, why not given the 2003 report identified this as an urgent priority?

Answer:

The Department of Health and Ageing has not specifically collected baseline data for the evaluations of the AP Lands COAG trial site. However, the Indigenous Communities Coordination Taskforce prepared a regional profile of the AP Lands at the commencement of the trials.

The first phase of the evaluation of the COAG trials will analyse the adequacy of existing baseline data and assess whether additional baseline data needs to be in place to effectively conduct an impact assessment at the end of the trials.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-069

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

Has the Department identified performance indicators for the trial? If so, when did you set them? What are they? When will you report on them? If not, when will you set them? What is the reason for the delay?

Answer:

There are no specific performance indicators for the trial. There is, however, an agreement to work on the five regional priorities that were identified in the draft Shared Responsibility Agreement which were:

- Improving the health and wellbeing of Anangu by:
  - implementing responses by all of the partners to the problem of substance misuse, and
  - improving availability and affordability of healthy food supplies;
- Improving educational attainment, training opportunities, employment opportunities and career pathways, especially for younger Anangu;
- **Improving access for Anangu to a wide range of social and community services by developing the infrastructure for regional delivery of basic services such as banking and financial facilities, postal and telecommunications services, and a range of Commonwealth government services eg Centrelink, Medicare easy claim, Job Network;**
- Improving physical infrastructure, especially the quality, reliability and affordability of essential services, the maintenance and upgrade of roads, air and other public transport and appropriately designed, constructed and maintained community housing; and
- **Supporting and strengthening existing regional governance structures**

There are no reports on performance indicators for the COAG trial. The COAG trials are based on a set of general objectives which include better coordination of programs and services, and the tailoring of government programs and services to the needs of communities.

Given the nature of these objectives, a set of specific performance indicators (such as those used to evaluate traditional government programs) is not appropriate for measuring the trial's effectiveness. Measurement of progress will need to be largely qualitative, and is best addressed through the evaluation process now in train. Existing government programs within the trial site continue to have their own performance indicators which reflect the aims of these programs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-070

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

Have you conducted any formal or informal evaluation of the trial? If so, we request that you provide us with a copy of any related documentation. If not, when do you plan to conduct and evaluation? What is the reason for the delay?

Answer:

All evaluations are being undertaken externally. The Office of Indigenous Policy Coordination is managing the evaluation of the AP Lands trial in collaboration with other Government agencies, State and Territory Governments and the Indigenous communities involved.

The Commonwealth has taken a two stage approach to evaluation of the COAG trials, with evaluations of all trial sites being undertaken in 2005-06 and again in 2007-08.

The first stage evaluations are now underway and will be completed in early 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-072

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

Does the Department intend on handing over responsibility for the trial to OIPC? If so, in what timeframe? Has the handover already begun? On what date will responsibility transfer?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-073

OUTCOME 7: Indigenous Health

Topic: COAG TRIAL

Written Question on Notice

Senator Evans asked:

Please list the dates of any visits made to the trial site by:
(a) Minister
(b) Secretary of the Department

Please also specific [sic] the reason for the visit.

Answer:

(a) The Minister for Health and Ageing, the Hon Tony Abbott MP, visited the Anangu Pitjantjatjara Lands (AP Lands) between 28 - 30 June 2005 to meet local community members and service providers.

The previous Minister for Health and Ageing, Senator the Hon Kay Patterson visited the AP Lands in May 2003 to officially launch the site. She was accompanied by the previous Minister for Immigration, Multicultural Affairs and Indigenous Affairs, the Hon Phillip Ruddock MP.

(b) The Secretary of the Department of Health and Ageing, Ms Jane Halton, has visited the AP Lands four times to meet local community members and service providers. The dates for each visit are:

- 5 – 7 December 2002
- 5 – 8 March 2003
- 21 – 24 May 2003
- 28 – 30 June 2005

In addition to visits to the AP Lands, the Secretary makes trips to either Adelaide or Alice Springs to attend regular TKP Regional Forum meetings and (previously) COAG Steering Committee meetings. This has included three of the four COAG steering Committee meetings (one meeting was held in Canberra) and five TKP Forum meetings.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-248

OUTCOME 7: Indigenous Health

Topic: WORKPLAN FOR FUTURE ACTION IN EAR AND HEARING HEALTH

Written Question on Notice and Hansard page CA 128-129

Senator Crossin asked:

(a) Where are you at with implementing the Workplan for Future Action in Ear and Hearing Health?
(b) Can you provide details about how you are implementing the Workplan?
(c) Are the six workforce strategies contained in the Report on Commonwealth Funded Hearing Services the same strategies that are being implemented in the Workplan?

Answer:

(a) A significant number of commitments outlined in the Workplan for Future Action in Ear and Hearing Health have been completed or are in progress.

(b) The following progress has been made in implementing actions from the Workplan for Future Action in Ear and Hearing Health:

Policy Principle 1: Position ear health within a comprehensive, population based approach to family, maternal and child health

Action	**Progress**
Consult with stakeholders in ear and hearing health on Child and Maternal Health across the continuum of care (embedding hearing health in a comprehensive child and maternal health approach).	Consultations have occurred with the National Aboriginal Community Controlled Health Organisation (NACCHO) in relation to embedding hearing in a comprehensive child and maternal health approach.

Reorient the Hearing Training and Equipment Program to an improved focus on the 0-5 age group within a comprehensive approach to child and maternal health.	The new Healthy for Life budget measure will provide opportunities for services to strengthen their approach to ear and hearing health within the 0-5 year age group through a comprehensive approach to Child and Maternal Health and Chronic Disease. Quality improvement principles and approaches in Child and Maternal Health and Chronic Disease are also central to Healthy for Life. In June 2005 the Australian Government announced the development of an annual Medicare funded Aboriginal and Torres Strait Islander Child Health Check from birth to 14 years of age. This item will provide access to regular and comprehensive health checks for Indigenous children to enable early detection of disease, to reduce the high rates of illness among Aboriginal and Torres Strait Islander children, including for ear and hearing health. This new item will be available for use by May 2006.
Provide information on the Office for Aboriginal and Torres Strait Islander Health (OATSIH) website on regional and jurisdictional programs, strategies and resources for ear and hearing health as part of Child and Maternal Health.	The Office of Aboriginal and Torres Strait Islander Health (OATSIH) website is currently under review.
Engage relevant stakeholders in environmental health issues that impact on ear and hearing health.	Environmental health issues that impact on ear and hearing health are being addressed through the implementation of the *National Strategic Framework for Aboriginal and Torres Strait Islander health 2003-2013*. The National Strategic Framework aims to influence the health impacts of the non-health sector including delivery of safe housing, water, sewerage and waste disposal and to improve standards of environmental health in Aboriginal and Torres Strait Islander communities. It emphasises the collaboration needed between Australian Government, State, Territory and local government agencies and aims to develop partnerships with, and obtain commitment from, other sectors whose activities impact on health.

Policy Principle 2: Promote skills development in the primary health care workforce in the clinical management of otitis media

Assess the uptake of the *Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations.*	OATSIH is supporting regional assessment and improvement of uptake of the Otitis Media Recommendations for Guidelines through a project auspiced by the Far Western and Regional Health Services (South Australian Department of Health), and involving the Royal Australasian College of Physicians, and six Aboriginal Community Controlled Health Services (see Background for further details).
Ensure *Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations* are incorporated into Australian Hearing's procedure manual for ear and hearing health training.	Australian Hearing incorporate the *Recommendations for Clinical Care Guidelines on the Management of Otitis Media in Aboriginal and Torres Strait Islander Populations* (the Guidelines) into their training, making reference to the Guidelines as evidence based treatment protocols.
Explore opportunities to progress a quality improvement process in Child and Maternal Health service delivery	Quality improvement principles and approaches in Child and Maternal Health and Chronic Diseases are central to Healthy for Life.

Policy Principle 3: Facilitate increased access to, and the earlier involvement of Ear, Nose and Throat Specialists and audiologists in the clinical management of ear disease

Investigate existing incentive programs for allied health providers and medical specialists to provide rural and remote services.	Existing incentive programs have been explored including the Specialist Outreach Scheme. There is scope for hearing health to utilise this program.

Policy Principle 4: Increase the capacity of the Commonwealth Hearing Services Program to respond to the tertiary hearing needs of Aboriginal and Torres Strait Islander peoples more adequately and flexibly

Consider the appointment of an Indigenous representative to the Hearing Services Advisory Committee.	An Indigenous representative was appointed to the Hearing Services Advisory Committee and is a member of the Hearing Services Consultative Committee which was formed this year.
Streamline access to Community Service Obligations funded services, Australian Hearing Specialist Program for Indigenous Australians (AHSPIA).	Administrative requirements for Aboriginal and Torres Strait Islander people to access Community Service Obligations funded hearing services have been simplified. Aboriginal and Torres Strait Islander people no longer need to obtain a referral from a General Practitioner prior to accessing the Australian Hearing Specialist Program for Indigenous Australians (AHSPIA).

Assess implications of changes to the eligibility for Commonwealth Hearing Services Program.	From 1 December 2005 eligibility to Australian Government Hearing Services Program for Aboriginal and Torres Strait Islander people will be expanded. The Program will be accessible to Aboriginal and Torres Strait Islander people aged 50 years and over, as well as to Aboriginal and Torres Strait Islander people participating in the Community Development Employment Program (CDEP).
Review delivery of services for Aboriginal and Torres Strait Islander people by Australian Hearing.	The Office of Hearing Services (OHS) is involved in discussions with Australian Hearing with regard to their strategies for service delivery with Aboriginal Community Controlled Health Organisations and Aboriginal Medical Services.
Pilot "Hearing Aid Bank" in remote communities.	In July 2003, OHS provided the Central Australian Aboriginal Congress (Congress), Northern Territory with over 100 behind the ear hearing aids. In 2004, OHS received feedback that significant progress had been made with the Hearing Aid Bank and discussions with health professionals had led to a collaborative framework that would result in ineligible Aboriginal and Torres Strait Islander people across the Northern Territory possibly accessing these hearing aids. A further supply of hearing aids to Congress was provided by OHS in January 2005. Bernafon is working with Congress and is providing change over shells and programming equipment free of charge.
Investigate opportunities for remote area Aboriginal Medical Services to become accredited providers of hearing devices.	Discussions have commenced with Aboriginal Medical Services to become accredited providers of hearing devices.

Policy Principle 5: Enhance and harness the role Aboriginal Health Workers play in the delivery of ear health services and health promotion in Aboriginal Community Controlled Health Services

Reorient the Hearing Training and Equipment Program to an improved focus on the 0-5 age group within a comprehensive approach to child and maternal health.	The new Healthy for Life budget measure will provide opportunities for services to strengthen their approach to ear and hearing health within the 0-5 year age group through a comprehensive approach to Child and Maternal Health and Chronic Disease. Quality improvement principles and approaches in Child and Maternal Health and Chronic Disease are also central to Healthy for Life. In June 2005 the Australian Government announced the development of an annual Medicare funded Aboriginal and Torres Strait Islander Child Health Check from birth to 14 years of age. This item will provide access to regular and comprehensive health checks for Indigenous children to enable early detection of disease, to reduce the high rates of illness among Aboriginal and Torres Strait Islander children, including for ear and hearing health. This new item will be available for use by May 2006.
Monitor development of best practice in health promotion and facilitate dissemination of relevant information.	The Department is exploring the use of the Health Promotion Officers within communities.
Explore opportunities to link e-informatics in health promotion for stakeholders.	The Department is engaged in a contract to develop the use of touch screens in Aboriginal Community Controlled Health Organisations.
Commonwealth to support Partnership Forum and sub committees in the development of intersectoral collaborative approaches to ear and hearing health.	A cross agency reference group including the Australian Government Departments of Health and Ageing, Family and Community Services, Education, Science and Training, and the Northern Territory Department of Health and Community Services was formed to examine the viability of establishing a centre of excellence in ear and hearing health and language development in Central Australia.

Policy Principle 6: Intersectoral collaborative approaches to develop and implement school ear health and hearing policies that advance the use of technological systems and training

Investigate the current use and future feasibility of video otoscopy and transmission of imaging in the early detection of Otitis media, particularly in localities where the availability of specialists is limited.	OATSIH has funded video otoscopes through the Expansion and Enhancement round and through the Hearing Training Equipment Contract.
Progress the use of soundfield amplification systems in all schools. Strengthen existing policy around soundfield amplification	Funding for soundfield amplification systems within schools is the responsibility of the States/Territories. State and Territory authorities are responsible for determining which students have the greatest need for additional assistance and provide funding accordingly.
Investigate innovative approaches for improved educational outcomes eg hearing hat.	The National Acoustic Laboratories, a research division of Australian Hearing, has conducted research into improving bone conduction hearing aid technology and fitting protocols. The Australian Government is evaluating this information.

(c) The six policy principles contained in the *Report on Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander Peoples: Strategies for Future Action* are the same six policy principles in the *Work Plan for Future Actions in Ear and Hearing Health*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-251

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING

Written Question on Notice and Hansard page CA 126-127

Senator Crossin asked:

(a) Do you know how many people there are with a known serious petrol sniffing habit in the central region?
(b) Do you know how many would be seriously disabled as a result of sniffing?
(c) How much does a disabled person cost the health care system in that region each year if they are diagnosed as being a sniffer?
(d) How many people are known to have died from petrol sniffing in that region?

Answer:

(a) It is not possible to provide exact numbers of petrol sniffers who are classed as having a serious sniffing habit in the central region. The most comprehensive data set is managed by the Nganampa Health Council. The 2004 survey of prevalence of petrol sniffing on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands showed that:
- over 14% of the population (222 individuals) on the APY Lands between the ages of 10-40 sniff petrol;
- over 20% of all males between the ages of 10-40 sniff petrol;
- nearly 9% of all females between the ages of 10-40 sniff petrol; and
- of those who sniff petrol, the largest group is 15-24 year olds, with 115 total users or 52% of petrol sniffers.

In addition, submissions to the Northern Territory Coronial Inquests indicated that there are some 500 sniffers in the southern part of the Northern Territory (NT), bringing the total number of sniffers in the cross border region (NT, South Australia and Western Australia) to around 700.

(b) The Legislative Assembly of the NT Select Committee on Substance Abuse in the Community – Petrol sniffing in remote NT communities (October 2004) estimated that 'there are currently 15 disabled ex-sniffers being cared for in Central Australia alone. It is anticipated that the number of ex-sniffers in Central Australia requiring full time care by Government will increase to 60 in the next ten years. These figures exclude numbers being cared for by family members.'

(c) The Northern Territory Parliament's Select Committee on Substance Abuse in the Community noted earlier this year that a conservative estimate of the cost to the NT of maintaining an ex-sniffer in that state is $160,000 per annum.

(d) The 2004 Evaluation of the Comgas Scheme reported 37 deaths from petrol sniffing, between 1999-2003, in SA, WA, and the NT. Unpublished ABS data reports there were 19 deaths registered in Australia for the period 1997-2003 where toxic effects of petroleum products was mentioned. Of these ten were identified as Indigenous with six from the NT. In a report in *The Australian* of 10 August 2005, forensic pathologist Dr Terry Sinton 'told the inquiry that between 50-60 people in the Territory had died in the past eight years as a result of petrol sniffing… Dr Sinton said about ten per cent of the deaths were directly related to petrol sniffing'.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-289

OUTCOME 7: Indigenous Health

Topic: RHEUMATIC FEVER

Written Question on Notice

Senator Crossin asked:

(a) What is the current rate of rheumatic fever in the Indigenous population?
(b) How does this compare to the rate in the population as a whole?
(c) What percentage of Indigenous people are left with heart disease as a consequence of rheumatic fever?

Answer:

(a) For the period 1998-2002, the Northern Territory's Top End rheumatic heart disease register reported the annual incidence rate of acute rheumatic fever among Aboriginal and Torres Strait Islander children aged 5-14 years as 245 per 100,000, and the Central Australia register a rate of 351 per 100,000.[5] Similar data are not available from other parts of Australia.

(b) There were no reported cases of acute rheumatic fever among non-Indigenous children living in the Top End of the Northern Territory and Central Australia in 2002.

(c) It is not known what percentage of Aboriginal and Torres Strait Islander people with acute rheumatic fever end up with rheumatic heart disease. Regular long-term treatment with injected antibiotics can prevent recurrence of acute rheumatic fever and the associated cumulative heart valve damage which results in rheumatic heart disease.

The Australian Government has provided funding to establish and support a rheumatic heart disease register in the Top End of the Northern Territory and Central Australia. This is administered by the Northern Territory Department of Health and Community Services and operates to coordinate evidence-based, individual management of patients with acute rheumatic fever and rheumatic heart disease.

5 AIHW: Field B. 2004. Rheumatic heart disease: all but forgotten in Australia except among Aboriginal and Torres Strait Islander peoples. Bulletin no. 16. AIHW Cat. No. AUS 48. Canberra: AIHW.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-252

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL IN CENTRAL AUSTRALIA

Written Question on Notice and Hansard page CA 125-126

Senator Crossin asked:

(a) How much money is currently committed to the Opal fuel program?
(b) Is that spread evenly across each of the four years?
(c) How many Central Australian communities will this roll-out cover?
(d) Can you provide me with a list of registered communities in receipt of Opal, and a list of those that will be receiving Opal (communities, roadhouses and pastoral properties)?
(e) What is the definition of the central desert region where Opal is to be rolled out?

Answer:
(a) Please refer to table.

Petrol Sniffing Funding						
	2004/05	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**Registration**
Ongoing Base funding ($)	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	42 communities
2005/06 Budget ($)		500,600	1,022,000	1,410,000	1,708,000	extra 23 communities
Central Australia Regional roll-out ($)		2,448,600	2,448,600	0	0	extra 6 communities, 7 roadhouses, and 9 Pastoral Properties
Total	**1,000,000**	**3,949,200**	**4,470,600**	**2,410,000**	**2,708,000**	**87 communities/sites**

The funding to supply non-sniffable fuel to registered remote Aboriginal and Torres Strait Islander communities is administered through the Comgas Scheme. It includes an annual recurrent allocation of $1 million to operate the scheme, which currently subsidises the supply of Opal, a non-sniffable fuel, to 42 participating communities.

$4.64 million is allocated over four years (2005-06 to 2008-09 financial years) to register an additional 23 communities. Additional funds have recently been allocated for the Australian Government's designated central desert region to add additional communities and sites over two years (2005-06 to 2006-07 financial years). By the end of the 2008-09 financial year it is anticipated at least 87 communities and sites nationally will be registered on the Comgas Scheme.

(b) No, this gradually increases over the four years, as staged registration of communities and sites to the scheme are planned.

(c) The Comgas Scheme currently subsidises the supply of Opal to the following remote Aboriginal communities within the Australian Government's designated central desert regional rollout area:

Northern Territory
- Kaltukatjara (Docker River)

South Australia
- Amata
- Kaljiti (Fregon)
- Indulkana
- Mimili
- Pipalyatjara
- Pukatja (Ernabella)
- Wattinuma
- Kanypi

Western Australia
- Warakurna
- Irruniytu (Wingellina)
- Papulankutja (Blackstone)

An additional six communities, seven roadhouses and nine private pastoral properties will be included in the rollout of Opal to the Australian Government's designated central desert region.

The six communities to be included in the rollout to the Australian Government's designated central desert area are: Kutjuta, Mutitjulu, Marla, Mintabie, Kalka, and Yunyarinyi. The seven roadhouses are: Mount Ebanezer, Curtin Springs, Wallara, Erlunda, Kukgera, Marla and Yulara.

Negotiations are underway to identify all of the pastoral properties in the region. In addition, there will be a limited supply of Opal available in Alice Springs, for residents visiting from surrounding communities and for visitors to those communities.

(d) A list of communities registered to receive Opal is attached at Attachment A.

A list of sites in the Australian Government's designated central desert region that will receive Opal fuel under the eight point plan is at Attachment B.

(e) The Australian Government's designated central desert region includes land in Western Australia, South Australia and the Northern Territory. The defined region currently includes Yulara Resort and extends down the Stuart Highway from Henbury through the Erlunda and Kulgera Roadhouses to Marla. The total geographical area is approximately 128,000 square kilometres.

Attachment A

COMMUNITIES REGISTERED TO RECEIVE OPAL

Community	Trading Name	Receiving Opal
NORTHERN TERRITORY – CENTRAL		
Kaltukatjara (Docker River)	Docker River Store	Y
Walungurru (Kintore)	Pulikutjarra Aboriginal Corporation	Y
Mt. Liebig	Watiyawanu Community Government Council	Y
Papunya	Papunya Social Club	Y
Apatula (Finke)		Y
Hermannsburg		Y
Areyonga		Y
NORTHERN TERRITORY – TOP END		
Kardu Numuda (Daly River Area) (Port Keat)		Y
Maningrida		Y
Numbulwar		Y
Milingimbi (Marthakal Homelands)		Y
Galiwinku (Elcho Island)		Y
Ramingining		Y
Warruwi (Goulburn Is)	Ajurumu Store	Y
Minjalang (Croker Island)		Y
Gapuwiyak	Gapuwiyak Community Incorporated	Y
Ngukurr (Roper River)		Y
WESTERN AUSTRALIA		
Papulankutja (Blackstone)	Blackstone Enterprises	Y
Cosmo Newbery		Y
Mantamaru (Jameson)	Jameson Store	Y
Kiwirrkurra		Y
Tjirrkali		Y
Patjarr		N
Wannan		Y
Warakurna	Warakurna Roadhouse	Y
Warburton	Warburton Roadhouse	Y
Irruniytu (Wingellina)	Wingellina Store	Y
Tjukurla	Tjukurla Roadhouse	Y
Wirrimanu (Balgo)		Y
Mulan (Lake Gregory)		N
Kanpa		N

SOUTH AUSTRALIA		
Amata	Amata Store	Y
Kaltjiti (Fregon)		Y
Indulkana	Indulkana Community Store	Y
Kanypi (also supply Murpatja)		Y
Mimili		Y
Pipalyatjara		Y
Pukatja (Ernabella)		Y
Maralinga (Oak Valley)		Y
Watarru		Y
Watinuma	Wattinuma Roadhouse	Y
QUEENSLAND		
Aurukun	Aurukun Shire Council	Y

Attachment B

COMMUNITIES/SITES RECEIVING OPAL IN AUSTRALIAN GOVERNMENT DESIGNATED CENTRAL AUSTRALIAN REGIONAL ROLL-OUT

Community
Kutjuta
Mutitjulu
Marla
Mintabe
Kalka
Yunyarinyi
Roadhouse
Mt Ebanezer
Curtin Springs
Wallara
Erlunda
Kukgera
Marla
Yulara
Pastoral Properties
9 properties to be identified

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-290

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Crossin asked:

How much money is currently committed to the Opal fuel program?

Answer:

The funding to supply non-sniffable fuel to registered remote Aboriginal and Torres Strait Islander communities is administered through the Comgas Scheme. It includes an annual recurrent allocation of $1 million to operate the scheme.

$4.64 million is allocated over four years (2005-06 to 2008-09 financial years) to extend the Scheme to additional communities.

On 12 September 2005 additional funding was announced by the Australian Government for the Central Australia Regional roll-out of non-sniffable fuel.

By the end of the 2008-09 financial year it is anticipated at least 87 communities and sites nationally will be registered on the Comgas Scheme.

Petrol Sniffing Funding						
	2004/05	**2005/06**	**2006/07**	**2007/08**	**2008/09**	**Registration**
Ongoing Base funding ($)	1,000,000	1,000,000	1,000,000	1,000,000	1,000,000	42 communities
2005/06 Budget ($)		500,600	1,022,000	1,410,000	1,708,000	extra 23 communities
Central Australia Regional roll-out ($)		2,448,600	2,448,600	0	0	extra 6 communities, 7 roadhouses, and 9 Pastoral Properties
Total	**1,000,000**	**3,949,200**	**4,470,600**	**2,410,000**	**2,708,000**	**87 communities/sites**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-295

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice and Hansard page CA 126 – 127

Senator Crossin asked:

(a) How many people in the Central Australian region are known to be seriously disabled as a result of petrol sniffing?
(b) How much does such a disabled person cost the health care system in each year?

Answer:

(a) The Australian Government cannot give a definitive answer to this question, however the Legislative Assembly of the Northern Territory (NT) Select Committee on Substance Abuse in the Community – Petrol sniffing in remote NT communities (October 2004) estimated that 'there are currently 15 disabled ex-sniffers being cared for in Central Australia alone. It is anticipated that the number of ex-sniffers in Central Australia requiring full time care by Government will increase to 60 in the next ten years. These figures exclude numbers being cared for by family members.'

(b) The Northern Territory Parliament's Select Committee on Substance Abuse in the Community noted earlier this year that a conservative estimate of the cost to the NT of maintaining an ex-sniffer in that state is $160,000 per annum.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-315

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

(a) What is the total of PHCAP appropriations spent by the Department over the last two years?

Answer:

(a) The total PHCAP funds either expended (or committed to capital works) for the delivery of Indigenous primary health care over the last two years is provided in the table below:

Financial Year	Expenditure ($ million)
2003-04	47.7
2004-05	64.8

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-317

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

(a) Is the PHCAP allocation in the 2005-06 Budget being distributed according to the 1999-2000 benchmark figures?

Answer:

(a) Yes. The 1999-2000 primary health care benchmark parameters are updated to reflect changes in population and Medicare Benefits Scheme utilisation. In addition to consideration of current primary health care benchmark funding levels, the funding is determined with regard to identified health need, the existing gap in service provision, and the capacity to develop and deliver a sustainable new service.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-339(a)

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

(a) What percentage of the funding allocated to PHCAP is targeted for training? Can you provide a breakdown of the amount on a state by state basis funds allocated for training, capacity building and board costs?

Answer:

(a) There is no specific target within PHCAP funding for training. However, it is anticipated that a proportion of PHCAP resources in 2005-06 will be applied by organisations for organisational development, including training, capacity building and board costs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-339(b)

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH PHCAP

Senator Crossin asked:

(b) Can you provide the specific allocations for 2005/06 in line with the information provided in question E04-205?

Information asked in E04-205 as follows:

(a) What is the allocation for primary health care services: (i) in total; and (ii) for each such service in particular for 2005-06?
(b) What is the allocation for substance use specific services: (i) in total; and (ii) for each such service in particular for 2005-06?
(c) What is the allocation for emotional and social wellbeing services: (i) in total; and (ii) for each such service in particular for 2005-06?
(d) What is the allocation for administration of the Patient Information and Recall System program for 2005-06?
(e) Can you give me a breakdown of the state and territory Bringing Them Home counsellor positions and the amount allocated to them?
(f) What funds will be allocated to the Indigenous substance abuse programs in 2005-06?
(g) What funds will be allocated to the 17 new clinic redevelopments or improvements and 15 new health staff houses and duplexes in remote areas and where will the new staff houses and duplexes be located? i.e. provide a list of capital works, the locations and the amounts.
(h) What amount of funds will be allocated in 2005-06 to the National Indigenous Australians' Sexual Health Strategy?

Answer:

Yes. (Please note that where applicable previous questions have been amended to reflect the change in financial year.)

(a) (i) The amount allocated to primary health care services, including Mental health care, in 2005-06 is $230 million. This excludes amounts for patient information and recall systems, workforce strategies, capital works, substance use services, Healthy for Life, Combating Petrol Sniffing and Bringing Them Home programs. To date $177 million has been contracted to primary health care services. There are various reasons why the balance of funds has not yet been contracted, including: finalisation of contracts is pending receipt of annual financial statements and audit reports; timeframes for development and approval of proposals for the Indigenous Primary Health Care 2005-06 Budget measure; delays in finalising major recurrent funding contracts with State Governments, with contracts not yet signed due to delays with the State Ministerial approval process.

(ii) Refer Attachment A.

(b) (i) As at 22 November 2005, the allocation for substance use specific services in 2005-06 is $20,883,465.
(ii) Refer Attachment B.

(c) (i) The allocation for Emotional and Social Wellbeing Services in 2005-06 is $8,170,543.
(ii) Refer Attachment C.

(d) The allocation for administration of the Patient Information and Recall System program for 2005-06 is $2,320,000.

(e) The breakdown of Bringing Them Home (BTH) Counsellors by State and Territory is shown below. Currently 106 positions are funded nationally. For the 2005-06 financial year funding for BTH Counsellors has been standardised at $94,018 per position. The one exception is the Counsellor at Ceduna, South Australia, which is funded for $105,347, reflecting the large region serviced, and the associated higher travel costs.

State/Territory	Number of Counsellors	Funding
Australian Capital Territory	4	$376,070
New South Wales	19	$1,790,033
Northern Territory	17	$1,598,298
Queensland	19	$1,786,337
South Australia	13	$1,327,579
Tasmania	2	$188,036
Victoria	13	$1,269,241
Western Australia	19	$1,786,335
TOTAL	**106**	**$10,121,929**

(f) $23.593 million has been allocated by the Office of Aboriginal and Torres Strait Islander Health in 2005-06 to the Indigenous substance abuse programs, including Combating Petrol Sniffing.

(g) Since the response which was provided to E04-205 there have been increases in the approved budgets for four projects. Details are in the table below:

Organisation Name	*Project Type*	*Project Location*	*Approved budget (excl GST)*
Northern Territory			
Ngaanyatjarra Health Service Aboriginal Corporation	Clinic	Alice Springs	$ 1,680,890
South Australia			
Pika Wiya Health Service Incorporated	Clinic	Copley and Neppabunna	$ 465,000
Western Australia			
Nangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	Clinic	Wiluna	$ 2,070,000
Mawarnkarra Health Service Aboriginal Corporation	Nurses Housing (2)	Roebourne	$ 180,000

(h) $10 million has been allocated for sexual health in 2005 - 06. An implementation plan for the Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-08 is being developed and will develop initiatives to better strategically target key outcomes in relation to sexual health.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-341

OUTCOME 7: Indigenous Health

Topic: EYE HEALTH

Written Question on Notice

Senator Crossin asked:

What has the department done to implement the review of the national ATSI Eye Health Program?

Answer:

The department has progressed a number of recommendations of the Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program (NATSIEHP). These include:

- Undertaking a national stock-take of the eye health equipment funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH). The stock-take will be completed at the end of November and will inform the development of any future equipment policies for the OATSIH and the current distribution of specialist eye health equipment across regions.
- The Department has been working with States and the Northern Territory through the Communicable Diseases Network Australia (CDNA) to develop the *National Guidelines for the Public Health Management of Trachoma in Australia.* These will address trachoma control measures, screening and data and are expected to be finalised by the end of 2005.
- The Health Policy Advisory Committee on Technology (HealthPACT) has considered the cost effectiveness of retinal camera screening in remote locations and provided advice to the Medical and Pharmaceutical Services Division (MPSD). MPSD and the OATSIH are progressing discussions regarding the possible introduction of an MBS item for ophthalmologists who read retinal photographs taken in remote locations.
- The Australian Government is currently reviewing the Visiting Optometrists Scheme (VOS) and OATSIH is represented on the Reference Group. That Review is due to report in December 2005.
- Consultations with State and Territory Governments are ongoing. A key direction is the integration of eye health activities into the delivery of comprehensive primary health care services within a chronic disease framework. This approach will improve the systematic detection of eye health conditions. The Aboriginal and Torres Strait Islander Adult Health Check will also assist in the detection of eye health conditions.
- The development of core competencies for Aboriginal and Torres Strait Islander Health Worker training (which will include eye health) is continuing.

- The development of a health performance framework for Aboriginal and Torres Strait Islander peoples is being progressed by the OATSIH.
- A draft National Eye Health Plan has been developed. This important new initiative proposes five key action areas that have the potential to lead to the prevention of avoidable blindness and low vision. This Plan will be presented to the Health Ministers at their November 2005 meeting.
- A draft National Chronic Disease Strategy has been developed and will be presented to the Health Ministers at their November 2005 meeting for endorsement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-342

OUTCOME 7: Indigenous Health

Topic: EYE HEALTH

Written Question on Notice

Senator Crossin asked:

What approaches have been taken to integrate eye health into primary health care?

Answer:

Aboriginal Community Controlled Health Services funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH) are provided with funding to deliver comprehensive primary health care, inclusive of a focus on eye health.

In addition to funding primary health care, Services are able to access Expansion and Enhancement funding to augment their eye health service delivery. Rather than prescribe a national approach to the integration of eye health within chronic disease programs and services, the Australian Government is supporting jurisdictional approaches to reorienting the program.

Eye health related activities have increased across Australian Government funded Aboriginal and Torres Strait Islander primary health care Services.

- The proportion of Services undertaking and/or facilitating optometrist specialist eye testing has increased from 40% in 1999-2000 to 63% in 2003-04.
- Optometrists worked at 47% of Services in 2003-04. This has increased from 21% in 1999-00.
- Eye health workers and eye health coordinators worked across 9% of Services in 2003-04 (an increase from 5% in 1999-2000).
- 65% of Services have conducted eye screening programs between 1999-2000 and 2003-04. [6]

6 Australian Government, 2003-04 and 1999-00 Service Activity Reporting (SAR) data

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-343

OUTCOME 7: Indigenous Health

Topic: EYE HEALTH - TRACHOMA

Written Question on Notice

Senator Crossin asked:

(a) What action is being taken to reduce the incidence of trachoma? What is the amount of money for 2005-06 allocated towards the trachoma program?
(b) What role does the Communicable Diseases Network Australia take in providing consistent collection of data?

Answer:

(a) The Australian Government is addressing trachoma through a number of new initiatives to monitor and respond more effectively to trachoma in Australia. These include a commitment to funding:
    - the establishment of a national trachoma surveillance and reporting unit that will collect, analyse and report on trachoma prevalence and control activities;
    - targeted workshops for public health unit staff and primary health care workers on new Communicable Diseases Network of Australia (CDNA) trachoma Guidelines; and
    - augmentation of existing State and Territory trachoma screening and control activities to bring them in line with the CDNA trachoma Guidelines.

    There is no national trachoma program; however, the Minister has approved funding of up to $920,000 over three years for the above initiatives with $320,000 allocated for 2005-06.

    The Australian Government has worked with States and the Northern Territory through the Communicable Diseases Network of Australia (CDNA) to develop the *National Guidelines for the Public Health Management of Trachoma in Australia* (Guidelines). These will ensure consistent screening and control measures for reducing the prevalence of trachoma. These Guidelines have been endorsed by CDNA and will be published early in 2006.

    The Australian Government supports the World Health Organization (WHO) recommended SAFE (surgery, antibiotics, facial cleansing and environmental health) treatment strategy for trachoma control, particularly through access to primary and secondary health care and the availability of antibiotics.

An important pharmacological intervention addressing trachoma is the availability of azithromycin. Six years ago, the Australian Government made azithromycin, the antibiotic for treating trachoma, available to remote Aboriginal Health Services at no cost.

(b) The Communicable Diseases Network of Australia have produced *National Guidelines for the Public Health Management of Trachoma in Australia.* These guidelines provide clear recommendations on data collection for trachoma. Trachoma is not a nationally notifiable disease in Australia, however some states and territories do collect data relating to trachoma and the recommendations in the aforementioned guidelines provide best practice framework for states and territories. CDNA does not currently collect data centrally on trachoma prevalence.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-058

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

(a) Has baseline data for the trial been identified (e.g. local and regional health data etc) for use in measuring the success of the trial? When was this dataset formally agreed on?
(b) If not, why not given the 2003 "Shared Responsibility, Shared Future" report identified this as an urgent priority? When will a baseline data be identified?
(c) If so, can a copy of this baseline data be provided, i.e. what indicators are included?
(d) If so, when did the Department start tracking this data?
(e) If so, has the Department done any analysis of the information collected in tracking the baseline data? Has this information been reported on? If so can a copy of that analysis and/or reports be provided?

Answer:

(a) The Department of Health and Ageing has not specifically collected baseline data for the evaluations of the AP Lands COAG trial site. However, the Indigenous Communities Coordination Taskforce prepared a regional profile of the AP Lands at the commencement of the trials.

(b) The first phase of the evaluation of the COAG trials will analyse the adequacy of existing baseline data and assess whether additional baseline data needs to be in place to effectively conduct an impact assessment at the end of the trials.

(c) (d) and (e) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-074

OUTCOME 7: Indigenous Health

Topic: COAG Trial

Written Question on Notice

Senator Evans asked:

(a) Can you provide the number and percentage of Indigenous staff in your agency at present? How many are working specifically on the COAG trial? What percentage?

(b) Can you provide the number and percentage of Indigenous staff in your agency in 2004 and 2003? If the number has decreased, please explain the reason.

Answer:

(a) As at 30 June 2005, the Department of Health and Ageing (the Department) employed 83 staff who identified as Aboriginal or Torres Strait Islander people. This is 1.96% of the total Departmental staff. The Department currently has 1.5 FTE (full-time equivalent) staff working exclusively on the Anangu-Pitjantjantjara COAG trial. One of these officers (1 FTE or 67%) is an Indigenous Australian.

(b) The number of staff who identified as Aboriginal or Torres Strait Islander people as at 30 June 2004 was 89 (2.16%) and as at 30 June 2003 it was 79 (1.93%).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-249

OUTCOME 7: Indigenous Health

Topic: COST OF ASTHMA SPACER DEVICES

Hansard page: CA 128

Senator Patterson asked:

Do you know how much spacers cost?

Answer:

Spacers can cost anywhere from $12 to $60 depending on type, location and whether a mask is required.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-250

OUTCOME 7: Indigenous Health

Topic: ASTHMA SPACER DEVICES

Written Question on Notice and Hansard page CA 127

Senator Crossin asked:

(a) What is the department doing to address the fact that asthma spacer devices are inaccessible to a substantial proportion of people attending Aboriginal community health services?
(b) Is there scope for an appropriation of funds from elsewhere for these devices to be provided to Aboriginal community health services?
(c) Is the department currently scoping any policy options on how these spacer devices might be made available through Aboriginal community-controlled health services?

Answer:

(a) Aboriginal Community Controlled Health Services (ACCHS) are funded to provide primary health care services, which includes asthma spacer devices as necessary.

(b) There is no specific appropriation for provision of spacers to ACCHS. ACCHS are funded to provide primary health care services, which includes asthma spacer devices as necessary.

(c) The Australian Government provides funding to ACCHS to deliver comprehensive primary health care services, which could include the purchase and distribution of asthma spacer devices by ACCHS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-253

OUTCOME 7: Indigenous Health

Topic: MUTITJULU SUBSTANCE ABUSE WORKER

Written Question on Notice and Hansard page CA 125

Senator Crossin asked:

(a) Has the OATSIH grant of $68,000 for Mutitjulu community to employ a substance abuse worker become available?
(b) Has the funding become available through the office of OATSIH in Alice Springs?
(c) How much funding has been provided?
(d) What is the funding expected to cover?
(e) Can you provide the details of whether other operational costs for the substance abuse worker are drawn from Mutitjulu's base funding?

Answer:

(a) Funding for a substance misuse worker for the Mutitjulu community has been provided to the local Aboriginal Community Controlled Health Service since 18 May 2005 on a recurrent basis. Funds allocated for this position in 2005-06 are $68,730 (GST exclusive).

(b) Funding has been allocated from the Office of Aboriginal and Torres Strait Islander Health (OATSIH), Northern Territory.

(c) To date, funding of $51,054.50 (GST exclusive) has been provided since May 2005.

(d) This funding is to cover the employment of a suitably qualified substance misuse worker to case manage people sniffing petrol, and to work with clients referred from other services in the region. The person currently employed in this position is a registered nurse, with tertiary qualifications in Alcohol and Other Drugs, who works flexible hours.

(e) Operational costs for this salaried position are included in the total funding amount.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-254

OUTCOME 7: Indigenous Health

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH PERFORMANCE FRAMEWORK

Written Question on Notice and Hansard page CA 125

Senator Crossin asked:

(a) What is the time line for the service activity report, drug and alcohol services report, and Bringing Them Home counsellors data collection?
(b) Would the framework would be at a state where I could ask about that in February?

Answer:

(a) The table below outlines the time line for the Service Activity Report (SAR), the Drug and Alcohol Service Report (DASR) and the Bringing Them Home (BTH) counsellors data collection for 2004-05.

Data collection	**Proposed date for Key Results Report**
SAR	May 2006
DASR	May 2006
BTH	June 2006

(b) An outline of the Framework is available now. A copy is attached.

Aboriginal and Torres Strait Islander Health Performance Framework

2005

Introduction

The health status of Aboriginal and Torres Strait Islander Australians is well documented with a life expectancy of around 17 years less than non-Indigenous Australians and death rates two to four times higher (ABS, 2004) (NATSIHC, 2003a). While significant improvements have been made in the health status of non-Indigenous Australians, the level of disadvantage for Aboriginal and Torres Strait Islander people remains alarming and in marked contrast to other comparable countries. In response to these harrowing statistics, the Australian, State and Territory Governments established the National Strategic Framework for Aboriginal and Torres Strait Islander Health to support a comprehensive and coordinated effort both across and beyond the health sector to address the complex and inter-related factors that contribute to the current health outcomes.

The Aboriginal and Torres Strait Islander Health Performance Framework has been developed by the Standing Committee on Aboriginal and Torres Strait Islander Health (SCATSIH). SCATSIH is a sub-committee of the Australian Health Ministers' Advisory Council (AHMAC) which reports to the Australian Health Ministers' Conference through AHMAC.

This Framework has been developed to provide the basis for quantitative measurement of the impact of the National Strategic Framework for Aboriginal and Torres Strait Islander Health (NSFATSIH). It will also provide an opportunity to streamline reporting on Aboriginal and Torres Strait Islander health and health care delivery. This document summarises the outcomes of the developmental work undertaken to identify the most appropriate framework and performance measures for the Framework. The performance measures selected for the Health Performance Framework are based on the key policy questions identified in the National Strategic Framework.

Reports against the performance measures outlined in this Aboriginal and Torres Strait Islander Health Performance Framework (HPF) will be produced biennially commencing in 2006. A number of measures are able to be reported now while others will require varying degrees of development and data improvement to enable reporting. SCATSIH will establish priorities for the data development with the aim of eventually reporting all the measures.

Developing the Framework

In developing the HPF it was important to consider:

- Other national and international health performance frameworks in terms of their approach, definitions and measures;
- Links to relevant areas of the NSFATSIH and other relevant national Aboriginal and Torres Strait Islander policy frameworks; and
- Contextual issues associated with the current status of Aboriginal and Torres Strait Islander health and health system development.

Selecting the Framework

The Australian National Health Performance Committee's (NHPC) Health Performance Framework was chosen as the model for this Aboriginal and Torres Strait Islander Health Performance Framework. The NHPC Framework is the endorsed national approach to health performance measurement in Australia and it also acknowledges the broad range of factors that influence health status and outcomes. In contrast, the health performance frameworks of many international jurisdictions did not include measures of social determinants of health.

The HPF adopts the NHPC definitions but adds consideration of the Aboriginal and Torres Strait Islander health context and poses policy questions relevant to that context.

The Aboriginal and Torres Strait Islander Health Context

The life expectancy of Aboriginal and Torres Strait Islander Australians is around 17 years less than for non-Indigenous Australians, and death rates are significantly higher. Indigenous infant mortality rates are almost twice the rate for total infants (ABS, 2004). After adjusting for age, Indigenous Australians are about twice as likely to be hospitalised as other people (AIHW, 2004).

Indigenous Australians are disadvantaged compared to other Australians in terms of a range of determinants of health including lower incomes, lower levels of education, employment and environmental infrastructure. These, in turn, contribute to higher rates of health risk behaviours in Aboriginal and Torres Strait Islander people such as smoking, alcohol misuse and lack of exercise (NATSIHC, 2003b).

National Policy Frameworks

The NSFATSIH, agreed to by all Australian Health Ministers in July 2003, endeavours to address the issues outlined above and puts forward proposals to improve access and equity. This is reflected in the ultimate goal of the NSFATSIH, which is:

'To ensure that Aboriginal and Torres Strait Islander peoples enjoy a healthy life equal to that of the general population that is enriched by a strong living culture, dignity and justice.'

An effective, efficient and equitable health system is an essential component for any whole of Government effort that seeks to address Indigenous disadvantage. However in addition to a responsive health system, action in areas such as education, employment, transport and nutrition is also required if sustainable health gains are to be achieved.

This work has also been informed by other relevant national and jurisdictional work and strategies designed to improve Aboriginal and Torres Strait Islander health.

Selection of Performance Measures for the Health Performance Framework

SCATSIH established a Technical Advisory Group to select the performance measures for the HPF. When selecting measures the Technical Advisory Group used criteria developed by SCATSIH and which were based on the NHPC criteria. The following process was used (outlined in detail in the full report on this Framework):

- In stage one, measures were short-listed for policy relevance, based on the policy questions identified by SCATSIH for each domain.
- In stage two, the short-listed measures were examined for technical merit and feasibility.
    - This was done to a limited extent only as the Technical Advisory Group agreed that it would be more appropriate to consider stage two as part of the future work to develop the selected measures.
- In stage three, the selected measures were considered as a whole to ensure there were no gaps and that there was an appropriate balance of measures across the HPF.

Scope of the Health Performance Framework

The HPF covers the entire health system including Indigenous-specific services and programs and mainstream services across the continuum of care. The Framework includes measures across the full continuum from Inputs, Processes, Outputs, and Intermediate Outcomes to Outcomes. This enables short to medium term measures of progress to be included and accommodates the different stages of development of services and systems.

In addition, the Framework includes indicators for health determinants that are outside of the health system. This is consistent with the whole of government approach recommended by the Council of Australian Governments.

The Aboriginal and Torres Strait Islander Health Performance Framework

The HPF has 3 Tiers and 18 domains (see Attachment A). In addition there are two overarching dimensions that apply across multiple domains. These dimensions, quality and equity, are described below.

Quality

Definition:

> *the quality of health care relates to delivering the best possible care and achieving the best possible outcomes for Aboriginal and Torres Strait Islander people every time they deal with the health care system or use the services of the health care system.*

Cultural security is an important element of quality for Indigenous Australians: ‘a commitment to the principle that the construct and provision of services offered by the health system will not compromise the legitimate cultural rights, views, values and expectations of Aboriginal people. It is a recognition, appreciation and response to the impact of cultural diversity on the utilisation and provision of effective clinical care, public health and health systems administration.’ (Houston)

Equity

Definition:

> *the state or ideal of being just, impartial, and fair such as everyone having the same chance of good health regardless of who they are, where they live, or their social circumstances.* (Anderson et al, 2003)

It is further recognised that given the existing health problems facing Aboriginal and Torres Strait Islander Australians, positive discrimination will be needed in order to achieve the same chance of achieving good health, for example, Indigenous Australians require a higher level of health expenditure on average than non-Indigenous Australians because they have greater need. The definition of equity also needs to acknowledge that the construct of health is different for Indigenous Australians and therefore the outcomes sought may be different (Mooney, 2003). There are cultural, geographic and language barriers to achieving equitable health outcomes that must also be addressed (Leeder, 2003).

Policy Questions

The following questions are pertinent to equity:

- What is the magnitude of the difference between Aboriginal and Torres Strait Islander Australians and non-Indigenous Australians in terms of health status and outcomes, determinants of health and health system performance?
- Is the gap widening or narrowing?
- Are health services being provided to Aboriginal and Torres Strait Islander peoples proportional to need?

Performance Measurement

Equity will be assessed in the HPF by comparing Indigenous and non-Indigenous Australians in the measures for each domain.

Tier 1 – Health Status and Outcomes

Health Conditions

Information on the prevalence, incidence and burden of disease and injury provides a baseline to evaluate trends in the population's health and a basis for comparing different population groups (eg Indigenous and non-Indigenous Australians).

Policy Questions

- What is the gap in the prevalence or incidence of health conditions between Indigenous and non-Indigenous Australians? Is this gap widening or narrowing over time?

- Which health conditions cause the highest morbidity in the Aboriginal and Torres Strait Islander population?

- Is the nature of the health conditions that cause significant morbidity in Aboriginal and Torres Strait Islander peoples changing over time, and if so how?

Human Function

Policy Questions

- What is the gap in terms of the human functioning of Indigenous Australians compared to non-Indigenous Australians? Is this gap widening or narrowing over time?

- How is the human functioning of Indigenous Australians changing over time?

- Are there types of human function limitation that Indigenous Australians are at particular risk of experiencing?

Life Expectancy and Well Being

Life expectancy at birth for Aboriginal and Torres Strait Islander peoples is currently 17 years less than for other Australians. The NSFATSIH identifies the following relevant aims:

To increase life expectancy to a level comparable with non-Indigenous Australians; and
To decrease mortality rates in the first year of life and decrease infant morbidity by improving well being and quality of life.

The concept of social and emotional wellbeing is important to Indigenous Australians and is considered distinct from mental illness. Aboriginal and Torres Strait Islander peoples experience higher rates of both social and emotional wellbeing problems and some mental disorders than other Australians. Social and emotional wellbeing problems can result from grief, loss, trauma, abuse, violence, substance misuse, physical health problems, child development problems, gender identity issues, child removals, incarceration, family breakdown, cultural dislocation, racism and social disadvantage.

Policy Questions

- What is the gap in life expectancy at birth between Indigenous Australians and the general Australian population? Is this gap changing over time?

- How do Aboriginal and Torres Strait Islander Australians rate their own general wellbeing (mental, social, physical and/or emotional) and how does this compare to the general population?

Deaths

Data collected for this domain will assist in identifying which population subgroups are most at risk of premature death from which conditions.

Policy Questions

- How large is the disparity in death rates between the Indigenous and non-Indigenous Australian population and is the gap widening or narrowing over time?
- What are the major causes of death amongst Indigenous Australians and how does this compare with the general population?
- Which groups within the Aboriginal and Torres Strait Islander population are at most risk of premature death, and for what causes?

Tier 2 – Determinants of Health

The NSFATSIH highlighted the importance of broader policy approaches to address health and non-health sector initiatives. It is important to consider the complex inter-related character of the determinants within Tier 2 of the Health Performance Framework. For example, Winkleby et al. (1990) found that lower levels of education, a key indicator of socioeconomic status (SES), were associated with a higher prevalence of health risk factors such as smoking and obesity.

Environmental factors

The physical environment in which people live plays a pivotal role in population health. Environmental health depends, among other things, on the buildings in which people live, the water they drink, the food they eat, the air they breathe, their ability to clean themselves, their clothes and their homes, the safe removal of waste, and control of pests (McMichael, 1993). Key Result Area 5 of the NSFATSIH aims to improve standards of environmental health, including housing and essential services, in Aboriginal and Torres Strait Islander communities.

Policy Questions

- What proportion of Aboriginal and Torres Strait Islander Australians are at risk due to environmental factors?
- What is the differential exposure between Indigenous and non-Indigenous Australians? Is this improving?

Socioeconomic Factors

Research has shown clear associations between the health status of Australians and socioeconomic factors such as education, employment and income. Generally, population groups with lower socioeconomic status have poorer health than those with higher socioeconomic status.

KRA6 of the NSFATSIH looks at wider strategies that impact on health, including the areas of employment and education.

Policy Questions

- What is the socioeconomic status of Aboriginal and Torres Strait Islander peoples (including education, employment and income)?

- What is the disparity between Indigenous and non-Indigenous Australians?

- Is this disparity changing over time and if so by how much?

Community Capacity

Community capacity is a critical factor in Indigenous health disadvantage. Grief, trauma and loss, were identified in the Ways Forward Report as highly significant problems for Aboriginal and Torres Strait Islander Australians (Swan and Raphael, 1995). These can stem from a range of factors intimately related to the health and capacity of communities and cultures. According to the report some of the social and community factors that can affect mental health were:

- the ongoing impact of colonisation;
- loss of land and culture;
- high levels of family separations, including forced separations;
- deaths in custody;
- domestic violence; and/or
- sexual and physical abuse.

Policy Questions

- What proportion of Indigenous Australians live in areas that lack characteristics associated with high levels of community capacity?

- What is the trend over time?

- How does this compare with the non-Indigenous population?

Health Behaviours

Poor diet, insufficient physical activity, excess alcohol consumption and smoking are common risk factors for many diseases and conditions including cancers, diabetes, heart disease and stroke.

Health behaviours are an important contributing factor for Aboriginal and Torres Strait Islander health disadvantage. However, the interpretation of this domain in the HPF must acknowledge the socioeconomic and structural factors that predispose Indigenous Australians to such risks. In other words risk behaviours at the individual level must be seen in the context of risk factors affecting populations (Kawachi *et al.* 1997).

This ensures that policy initiatives move beyond a narrow focus of individual blame to develop an understanding of the systematic factors that initiate and maintain risky health behaviours.

Policy Questions

- What proportion of Indigenous Australians are at risk due to health behaviours? How does this compare to non-Indigenous Australians.

- Is the disparity between Indigenous and non-Indigenous Australians improving?

Person-related factors

Person-related factors include age, genetic and biomedical characteristics, which may manifest as particular genetic conditions or predispositions to chronic diseases.

Policy Questions

- What proportion of Indigenous Australians are at risk due to person related factors?

- Is there a differential prevalence between Indigenous and non-Indigenous Australians and if so what is the magnitude and direction of the difference?

Tier 3 – Health System Performance

Tier 3 of the HPF aims to measure the health system's performance towards meeting the health needs of Aboriginal and Torres Strait Islander peoples as identified in NSFATSIH.

Effective

Effectiveness is about achieving the 'desired outcome'. However, it is important to recognise that achieving the ultimate 'desired outcome' may not be feasible in the short to medium term due to the much poorer health status of Aboriginal and Torres Strait Islander Australians, the complexity of their health issues, the health system for Indigenous Australians is currently under development and contributing factors from outside the health system.

Policy Questions

- Is the Australian Health Care System effective for Aboriginal and Torres Strait Islander Australians?

Appropriate

Care that is relevant to the needs of Indigenous Australians needs to be based on appropriate definitions of health, an understanding of the health conditions of Indigenous Australians.

Policy Questions

- Is the Australian Health Care System providing care appropriate to the needs of Aboriginal and Torres Strait Islander Australians based on culturally appropriate established standards?

Efficient

Efficiency is about whether the health system achieves outcomes with the most cost-effective use of resources. There is considerable evidence that primary health care interventions are more cost effective than care provided in acute care settings (Tengs *et al.* 1995).

The WHO have argued that cost-effectiveness by itself is relevant for achieving the best overall health, but not necessarily for the second health goal, that of reducing inequality. Any analysis of health system efficiency for Indigenous Australians must take into account the large inequalities in health status and the additional cost of service provision in remote areas.

Policy questions

- To what extent is the maximum benefit being obtained within available resourcing?

- Is the most efficient allocation of funds between primary health care and acute care being achieved for Aboriginal and Torres Strait Islander peoples?

Responsive

Policy Questions

- To what extent does the Australian health care system reflect Aboriginal and Torres Strait Islander values?

Accessible

Accessibility is the ability of people to obtain health care as needed. There are multiple factors that affect whether health care is accessible, such as:

- Geographic barriers to health care services.
- Availability of transport
- Discrimination, or perceived discrimination, from health care services or providers
- Language and cultural barriers
- Affordability of health care and pharmaceuticals.

Policy Questions

- Is the Australian Health Care System accessible to Aboriginal and Torres Strait Islander Australians?

Safe

Safety is about whether actual or potential harm caused by contact with health system has been reduced to acceptable limits.

Policy Questions

- Is the Australian Health Care System safe for Aboriginal and Torres Strait Islander Australians?

- Are the risks associated with delivery of health care identified and managed?

Continuous

Policy Questions

- Is the delivery of health care provided in a coordinated and continuous manner across the continuum of care for Aboriginal and Torres Strait Islander peoples?

Capable

Capability refers to the capacity or competence (whether at an individual or service level) to provide health services and interventions based on skills and knowledge.

Staff turnover and retention is a significant issue for health services in relation to the skills and knowledge base of health staff.

The capacity to provide training for staff in remote areas is challenging for health services due to the distance/time required travelling to training and the lack of access to replacement staff to back fill for those attending training.

The diversity and complexity of Aboriginal and Torres Strait Islander cultures is another important issue here. The availability of health services including mainstream health services that are culturally equipped to provide services to Aboriginal and Torres Strait Islander peoples is one of the key factors that will contribute to improved health outcomes (Health Department of Western Australia, 2003).

Policy Questions

- Do the people/services providing health care to Aboriginal and Torres Strait Islander Australians have the relevant qualifications, skills and experience (clinical and cultural)?

Sustainable

Sustainability is about whether the health system has sufficient capacity to provide the necessary infrastructure now and into the future.

Measuring the sustainability of the health system for Aboriginal and Torres Strait Islander peoples is complicated by the fact that the Indigenous health system is still under development and additional issues arising in remote areas. Services and systems need to continue to be strengthened to effectively meet the health needs of the Aboriginal and Torres Strait Islander population. This should be through:

- investment in known effective care and commensurate with need; and
- addressing gaps in service provision for Indigenous Australians (eg investments in infrastructure and workforce development).

Policy Questions

- Is there sufficient funding to develop a sustainable health care system for Aboriginal and Torres Strait Islander Australians? Are resources adequate over the longer term?

- To what extent are Aboriginal and Torres Strait Islander Australians participating in the policy and planning process, service delivery and the management of health services?

Future Directions – Development and Implementation

Implementation of the Health Performance Framework will involve the following stages:

- Developing technical specifications for each performance measure. This will include:
    - Defining in detail what each performance measure is designed to monitor in relation to the policy questions in the Health Performance Framework;
    - Where the performance measure requires conceptual development, an outline of the work/research required would be identified. In some cases this development work may take several years.
    - Analysis of existing national data collections to identify appropriate data sources for each performance measure taking into consideration data quality issues and the relevance to each measure. It is intended to utilise existing national collections wherever possible. Make recommendations on which performance measures should be reported on in 2006.
    - Identification of data development requirements in terms of gaps in existing data collections and data quality improvements needed.
    - Prioritise the measure development and data development work based on policy relevance. This stage includes specifying the work required for each performance measure, the organisation(s) responsible and likely timeframes to reach reporting stage.
    - Specify the reporting structures for each performance measure including tables and graphs, caveats on the data, statistical analysis required, policy analysis and linkage to the key policies in Aboriginal and Torres Strait Islander health.

- Reporting against the performance measures for inclusion in each report, with additional measures incorporated as development work proceeds.

Attachment A - Aboriginal and Torres Strait Islander Health Performance Framework Performance Measures

<table>
<tr><th colspan="5">Health Status and Outcomes (Tier 1)</th></tr>
<tr><th>Health Conditions</th><th>Human Function</th><th>Life Expectancy and Wellbeing</th><th colspan="2">Deaths</th></tr>
<tr>
<td>• Low birthweight infants
• Top reasons for hospitalisation by principle diagnosis
• Hospitalisation ratios for injury and poisoning by age group
• Hospitalisation for pneumonia
• Circulatory disease
• Acute rheumatic fever and rheumatic heart disease
• Prevalence of high blood pressure
• Prevalence of Diabetes
• End stage renal disease
• Decayed-missing-filled-teeth DMFT (adult) & dmft (children)
• HIV/AIDS, hepatitis C and sexually transmissible infection notification rates
• Children’s hearing loss</td>
<td>• Prevalence of severe or profound core activity restriction by age and sex
• Number of children with special needs(aged 0-4) and (5-18)
• A measure (to be developed) of community functioning</td>
<td>• Life expectancy for total population at birth by sex
• Perceived health status
o health ≥ good, female, all ages
o health ≥ good, male, all ages
• Median age of death
• Social and emotional wellbeing</td>
<td colspan="2">• Infant mortality rate
• Perinatal mortality
• Rates of SIDS
• All causes age standardised deaths rates
• Standardised mortality ratios for leading causes
o Standardised mortality ratios for circulatory diseases
o Standardised mortality ratios for injury and poisoning, including suicide
o Standardised mortality ratios from respiratory diseases and lung cancer
o Standardised mortality ratios from diabetes
o Standardised mortality ratios from cervical cancer
o Standardised mortality ratios from other cancers
• Maternal mortality</td>
</tr>
<tr><th colspan="5">Determinants of Health (Tier 2)</th></tr>
<tr><th>Environmental Factors</th><th>Socioeconomic Factors</th><th>Community Capacity</th><th>Health Behaviours</th><th>Person-related Factors</th></tr>
<tr>
<td>• Access to functional Housing with Utilities – This measure includes proportion of dwellings with access to electricity or gas, clean water and functional sewerage
• Overcrowding in housing
• Appropriate storage of food and healthy standards
• Environmental tobacco smoke: children under 15 years who live in a household with a smoker</td>
<td><u>Education</u>
• Educational status of the adult population
• Years 10 and 12 retention and attainment
• Post secondary education – participation and attainment
• Year 3, 5 and 7 literacy and numeracy
• Educational status of women and mothers
<u>Employment</u>
• Employment status (full-time/part-time) by sector (public/private), industry and occupation
o CDEP participation
<u>Income</u>
• Sources of income
• Household and individual income
• Home ownership by tenure type
• Income poverty
<u>Disparity index which would cover the elements of this domain</u>
• A combined index of disadvantage, economic resources and of education and occupation</td>
<td><u>Demographic information</u>
• Dependency ratio– including identification of the age distributions within the ratio
• Single-parent families by age group
<u>Safety and Crime</u>
• Community safety
• People in prison custody
• Substantiated notifications of child abuse
o Children on long term care and protection orders
• Rates of kinship care
<u>Other capacity measures</u>
• Transport
• Proportion of Indigenous people with access to their traditional lands</td>
<td><u>Tobacco, alcohol and other drug use</u>
• Tobacco covering age/sex
• Tobacco age at commencement.
• Tobacco use during pregnancy
• Harmful and hazardous alcohol consumption
• Drug and other substance use including inhalants
<u>Physical activity</u>
• Level of physical activity and inactivity
<u>Nutrition</u>
• Dietary behaviour including levels of intake of sweetened beverages, fruit and vegetable and also fat intake
• Breastfeeding practices
<u>Other health behaviours</u>
• Self reported unsafe sexual practices</td>
<td>• Prevalence of overweight and obesity</td>
</tr>
</table>

Health System Performance (Tier 3)		
Effective	**Appropriate**	**Efficient**
• Measures of chronic disease management. This would include measures that are relevant to o Diabetes o Cardiovascular o Renal o Respiratory o Cancers o Chronic mental illness management • Antenatal care • Ambulatory sensitive/preventable hospital admissions • Key procedures - differentials (could be surgery rates eg cataract surgery) • Interventions o Immunisation (child and adult) o Cancer screening (in particular cervical) • Access to brief interventions and broader health promotion (particularly for tobacco and alcohol)	• Due to the similarity of definition between Effective and Appropriate it was decided the measures selected would be relevant to both domains. The measures are therefore only listed once under Effective.	• Avoidable and preventable admission • Avoidable and preventable deaths
Responsive	**Accessible**	**Safe**
• Consumer satisfaction o A measure of people 'voting with their feet', such as discharge against medical advice o Access to mental health services • Governance o A measure of competent governance systems will be a priority for data development	• Access to services by types of service compared to need (eg primary care, hospital, dental and allied health and post acute care and palliative care) • Affordability of health services including, but not limited to access to bulk billing • Availability of pharmaceuticals o not filling prescriptions due to cost o Pharmaceutical Benefits Scheme expenditure per capita by region • Access to after hours primary health care o A proxy measure could be the use of Emergency Departments for triage category 4 & 5 (ie problems that could be dealt with within a primary health care setting)	• No performance measures are included for this domain: o The measures that fit within this domain are not considered a high priority for the HPF as they are not likely to be issues that significantly and specifically affect Aboriginal and Torres Strait Islander peoples. o It is considered more appropriate that the NHPC report against such measures and include disaggregations by Indigenous status in keeping with its approach to determine 'is it the same for everyone'.
Continuous	**Capable**	**Sustainable**
• Care Planning – a measure of the proportion of clients with preventable chronic diseases managed on care plans will need to be developed as there is currently no mechanism to enable it to be measured • Rates and usage of Enhanced Primary Care items on MBS • Use of cancer treatment protocols for Indigenous vs non-Indigenous Australians • Extent to which individuals have a regular GP or health service	• Accreditation across service types o This will be measured in areas where a high proportion of the population is Indigenous because if it was measured across Australia it becomes a mainstream measure • Aboriginal and Torres Strait Islander people in Tertiary Education for health related disciplines (eg nurses, doctors and other allied health professions) • Proportion of Aboriginal and Torres Strait Islander people in health workforce	• Expenditure on Aboriginal and Torres Strait Islander health compared to need o This will draw on information in the Report on Health Expenditures for Aboriginal and Torres Strait Islander people and o Will be reported as a proportion of total expenditure on health (ie Indigenous and non-Indigenous) and over time • Relative per capita expenditure across population health, primary health care and acute care • Recruitment and retention of clinical and management staff (including GPs)

References

ANDERSON, G., PETROSYAN V. AND HUSSEY P., 2003. *International Working Group on Quality Indicators: Working paper on Disparities Indicators in Five Countries*. John Hopkins University.

AUSTRALIAN BUREAU OF STATISTICS, 2004. *Deaths Australia 2003*. ABS Cat. No. 3302.0, Canberra: ABS.

AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE (AIHW), 2004. *Australian Hospital Statistics 2002-03.* AIHW Cat. No. HSE 32, Canberra: AIHW.

HOUSTON S. [no date]. *Aboriginal Cultural Security, A Background paper.* Available from: www.aboriginal.health.wa.gov.au/htm/aboutus/Cultural%20Security%20Discussion%20Document.pdf [Accessed 4 July 2005].

KAWACHI I., KENNEDY B.P., LOCHNER K., PROTHROW-STITH D., 1997. Social capital, income inequality, and mortality. *American Journal of Public Health 1997,* vol. 87, pp. 1491-1498.

LEEDER, S. R., 2003. Achieving equity in the Australian healthcare system. *Medical Journal of Australia*, Vol 179: 475-478.

MCMICHAEL. A, 1993. *Planetary overload*. Cambridge: Cambridge University Press.

MOONEY G., 2003. *Here's a recipe for a more equitable health care system in Australia* [online]. Available from: http://www.onlineopinion.com.au [Accessed 26 May 2005].

NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH COUNCIL (NATSIHC),2003a. *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Framework for Action by Governments*. Canberra: NATSIHC.

NATIONAL ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH COUNCIL (NATSIHC), 2003b. *National Strategic Framework for Aboriginal and Torres Strait Islander Health: Context.* Canberra: NATSIHC.

SWAN P. AND RAPHAEL B., 1995. *Ways Forward – National Consultancy Report on Aboriginal and Torres Strait Islander Mental Health*. Canberra: AGPS.

TENGS, T. & et al, 1995. Five-hundred life-saving interventions and their cost effectiveness. *Risk Analysis*, vol. 15, pp. 369-391.

WINKLEBY, M.A., FORTMANN, S.P. & CARRETT, D.C., 1990. Social Class Disparities in Risk Factors for Disease: Eight-Year Prevalence Patterns by Level of Education. *Preventive Medicine*, vol. 19, pp. 1–12.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-286

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH - HIV/AIDS

Written Question on Notice

Senator Crossin asked:

a) What is the current rate of HIV/AIDS in the Indigenous population?
b) How does this compare to the rate in the population as a whole?
c) How much of this infection is as a result of heterosexual sex transmission?
d) What is the STD profile of those who are HIV positive?
e) What is the main source of infection with HIV/AIDS for the Indigenous population?
f) What is being done to address this issue?
g) How many people who are HIV positive are receiving medication?

Answer:

a) In 2004 the rate of HIV diagnoses in the Aboriginal and Torres Strait Islander population was 5.2 per 100,000. In 2004 the rate of AIDS diagnoses in the Aboriginal and Torres Strait Islander populations was 3.6 per 100,000.

b) In 2004 the rate of HIV diagnoses in the non-Indigenous population was 4.7 per 100,000. In 2004 the rate of AIDS diagnoses in the non-Indigenous population was 0.8 per 100,000.

c) Among Aboriginal and Torres Strait Islander HIV cases, 36.1% was attributed to heterosexual contact.

d) Data on the STI profile of Aboriginal and Torres Strait Islander people who are HIV positive is not reported.
In 2004, the rate of diagnosis for sexually transmissible infections per 100,000 population in Aboriginal and Torres Strait Islander people in the Northern Territory, South Australia, Victoria and Western Australia was:
   - 1234 for chlamydia;
   - 1404 for gonorrhoea; and
   - 301 for syphilis.

e) Among Indigenous HIV cases, an equal proportion of diagnoses were attributed to male homosexual contact (36.1%) and heterosexual contact (36.1%).
f) The Australian Government has recently launched the National HIV Strategy 2005-2008, the National Sexually Transmissable Infections Strategy 2005-2008 and the National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008.

These strategies collectively aim to guide action to reduce the transmission and morbidity of new HIV/AIDS infections through improvements in:

- health promotion, education and awareness of transmission and trends in infections;
- access to testing, diagnosis, treatment and care; and
- surveillance and research.

g) 7865 people living with HIV infection in Australia in 2004 were treated with antiretroviral therapy, which is 53% of all people with HIV. Data is not available for the number of Aboriginal and Torres Strait Islander who are HIV positive that are receiving medication.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-287

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH - HEPATITIS C

Written Question on Notice

Senator Crossin asked:

(a) What is the current rate of hepatitis C in the Indigenous population?
(b) How does this compare to the rate in the population as a whole?
(c) What is being done to address this issue?

Answer:

(a) and (b) The overall per capita rate of new diagnoses of hepatitis C infection has declined from 107.2 (20,188 cases) in 2000 to 66.0 per 100,000 population (13,028 cases) in 2004. Of these 13,028 cases, 8,517 cases did not identify the origin of the person, 3,898 cases were non-Indigenous people and 613 were Aboriginal and Torres Strait Islander peoples.

(c) The *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008* specifically focuses on the priorities and special issues that are unique to the prevention and treatment needs of Aboriginal and Torres Strait Islander peoples. It aims to reduce the transmission of, and morbidity caused by, these health conditions within this target group by improving:
- access to testing, diagnosis, treatment and care of sexually transmissible infections and blood borne virus
- surveillance and research activities; and
- community awareness.

The Australian Government has also developed the *National Hepatitis C Strategy 2005-2008* to improve sexual health across the entire Australian population.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-288

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH - CHLAMYDIA

Written Question on Notice

Senator Crossin asked:

(a) What is the current rate of Chlamydia infection in the Indigenous population?
(b) How does this compare to the rate in the population as a whole?
(c) What is being done to address this issue?

Answer:

(a) The rate of diagnosis of Chlamydia in Aboriginal and Torres Strait Islander people in the Northern Territory, South Australia, Victoria and Western Australia rose from 658 per 100,000 population in 1999 to 1,234 per 100,000 population in 2004.

(b) Chlamydia was the most frequently reported notifiable condition in Australia in 2004 with 35,189 diagnoses. The population rate of diagnosis of Chlamydia more than doubled over the past five years, from 91.4 (16,953 cases) in 2000 to 186.1 per 100,000 population in 2004.

This rate is still well below the rate for Aboriginal and Torres Strait Islander population, refer to part (a) above.

(c) The *National Aboriginal and Torres Strait Islander Sexual Health and Blood Borne Virus Strategy 2005-2008* specifically focuses on the priorities and special issues that are unique to the prevention and treatment needs of Aboriginal and Torres Strait Islander peoples. It aims to reduce the transmission of, and morbidity caused by, these health conditions within this target group by improving:
- access to testing, diagnosis, treatment and care of sexually transmissible infections and blood borne virus;
- surveillance and research activities; and
- community awareness.

The Australian Government has also developed the *National Sexually Transmissible Infections Strategy 2005-2008* to improve sexual health across the entire Australian population.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-292

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Crossin asked:

How many communities which will not get OPAL fuel have indicated to the Department that they want this fuel?

Answer:

To date all remote Aboriginal and Torres Strait Islander communities who have applied for registration onto the Comgas Scheme have been registered under the Scheme. Three communities are currently being considered.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-296

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice and Hansard page CA 127

Senator Crossin asked:

How many people are known to have died from petrol sniffing in that region?

Answer:

The 2004 Evaluation of the Comgas Scheme reported 37 deaths from petrol sniffing, between 1999-2003, in South Australia, Western Australia, and the Northern Territory (NT). Unpublished ABS data reports there were 19 deaths registered in Australia for the period 1997-2003 where toxic effects of petroleum products was mentioned. Of these ten were identified as Indigenous with six from the NT. In a report in *The Australian* of 10 August 2005, forensic pathologist Dr Terry Sinton 'told the inquiry that between 50-60 people in the Territory had died in the past eight years as a result of petrol sniffing… Dr Sinton said about ten per cent of the deaths were directly related to petrol sniffing'.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-297

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Crossin asked:

a) When will the Department make a decision about expanding the roll-out of OPAL fuel?
b) On what basis will such a decision be made?

Answer:

a) The decision to expand the roll-out of Opal fuel has been made as part of the 2005-2006 Budget and the development of the eight point plan for the Australian Government designated central desert region of central Australia.

b) Decisions to expand the roll-out of Opal are either made to individual remote Aboriginal and Torres Strait Islander communities on an application basis, or as part of a whole-of-government regional approach (eg the Australian Government designated central desert region of central Australia).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-312

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM

Written Question on Notice

Senator Crossin asked:

(a) Does the Department agree that regional planning processes, funds pooling and indexed per-person formula funding (up to an agreed benchmark) remain central to efforts to improve primary health care by Indigenous Australians?

Answer:

(a) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-313

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

(a) Can the Department confirm that it remains committed to the PHCAP funding model as originally agreed by Government, within constraints imposed by limited funding allocations?

Answer:

(a) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-314

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

(a) What are the Department's estimates of the funding required to implement PHCAP up to the benchmark funding level in Aboriginal communities over the next 5 years?

(b) How large is the funding gap based on current allocations?

Answer:

(a) As at 1 July 2005, approximately $250 million in additional funding would be required to achieve the primary health care benchmark funding level. If this were to be achieved over the next five years this would equate to approximately $50 million in additional recurrent funds provided each year.

(b) See response to part (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-316

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

(a) Over the last two years, what proportion has been allocated to approved PHCAP sites for roll-out of primary health care (as per PHCAP program parameters), compared with the proportion spent on other ad-hoc projects?

Answer:

(a) Over the last two years, over 98% of PHCAP funding has been allocated towards the provision of primary health care service expansion and enhancement activities. The remaining funds were allocated towards activities such as the review of the Australian Government's Aboriginal and Torres Strait Islander Primary Health Care Program, the establishment of Medicare Australia Indigenous liaison officers, and information material for Indigenous service providers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-325

OUTCOME 7: Indigenous Health

Topic: ASTHMA SPACER DEVICES

Written Question on Notice and Hansard page CA 127

Senator Crossin asked:

It does not appear that spacer devices can be provided under funding from the PBS as it can fund only medication – not devices. Is there scope for an appropriation of funds from elsewhere to provide for these devices? For example, the Dept of Veterans Affairs provides funding for devices and this appears in the Pharmaceutical Benefits Schedule.

Answer:

There is no specific appropriation for provision of spacers to Aboriginal Community Controlled Health Services (ACCHS). ACCHS are funded to provide primary health care services, which includes asthma spacer devices as necessary.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-326

OUTCOME 7: Indigenous Health

Topic: ASTHMA SPACER DEVICES

Written Question on Notice and Hansard page CA 127

Senator Crossin asked:

Is the department currently scoping any policy options on how these important devices might be made available through ACCHS for optimal asthma treatment?

Answer:

The Australian Government provides funding to Aboriginal Community Controlled Health Services (ACCHS) to deliver comprehensive primary health care services, which could include the purchase and distribution of asthma spacer devices by ACCHS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-331

OUTCOME 7: Indigenous Health

Topic: HEALTHY FOR LIFE PROGRAM

Written Question on Notice

Senator Crossin asked:

Can you provide a breakdown of how the $62.9m under the Healthy for Life Program will be spent?

Answer:

The *Healthy for Life* program provides $102.4 million over four years, from 2005-06 to 2008-09.

Year	2005/06	2006/07	2007/08	2008/09	Total
Administered Expenses ($ million)	9.23	18.40	27.55	36.75	91.93
Departmental Expenses ($ million)	1.97	2.95	2.89	2.64	10.45
Total	11.20	21.35	30.44	39.39	102.38

In 2005-06, funding will be provided for establishment of the sites, development of resources to assist sites and establishment of data collection and evaluation processes.

In subsequent years funding is provided for direct service delivery for over 80 sites. Ongoing data collection and evaluation will continue in the out years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-332

OUTCOME 7: Indigenous Health

Topic: TOWNSVILLE ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH SERVICE

Written Question on Notice

Senator Crossin asked:

How much money was allocated towards the Mums and Babies program at the Townsville Aboriginal and Torres Strait Islander health service?

Answer:

Townsville Aboriginal and Islanders Health Services received funding of $145,000 per year in 2002/03 and 2003/04, as part of the Child and Maternal Exemplar Site Initiative. In 2004/05, recurrent funding of approximately $100,000 was allocated to the *Mums and Babies Program,* under the Primary Health Care Access Program (PHCAP) Enhancement and Expansion funding round.

In 2005/06, Townsville Aboriginal and Islanders Health Services received approximately $2.63 million for the provision of comprehensive primary health care, inclusive of funding for the *Mums and Babies Program.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-333

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH – COMMONWEALTH PROGRAMS

Written Question on Notice

Senator Crossin asked:

What other commonwealth programs are funded that are targeted at pregnant women and children in this outcome?

Answer:

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) provides funding to Aboriginal and Torres Strait Islander primary health care services for the provision of comprehensive primary health care. In 2003/04, 84% of OATSIH funded primary health care services reported that they provided dedicated women's health programs, 70% reported that they delivered antenatal/maternal health programs, 79% of services stated that they provided child immunisation and 71% stated that they provided child growth monitoring services.

There has been significant progress to date in the implementation of expanded primary health care services for Aboriginal and Torres Strait Islander people through the Primary Health Care Access Program (PHCAP). Under PHCAP, funding has been allocated to the following activities: additional health service delivery staff; other service support positions; capital works; patient transport services; screening and diagnostic equipment; training for exiting staff to enhance their clinical or management skills; purchase and integration of new IT infrastructure and service planning and improvement activities. This funding can be used to benefit existing or developing programs for Aboriginal and Torres Strait Islander pregnant women and children.

In the 2005/06 Budget the *Healthy for Life* initiative was announced. *Healthy for Life* provides $102.4 million over four years to improve the health of Indigenous mothers, babies and children, improve the early detection and management of chronic disease and, over time, reduce the incidence of adult chronic disease. *Healthy for Life* is focused on primary health care services that deliver health care to Aboriginal and Torres Strait Islander populations.

The OATSIH Child and Maternal Health Exemplar Site Initiative commenced implementation in 2002/03. From 2002/03 to 2003/04, Townsville Aboriginal and Islanders Health Services received a total of $290,000 under the initiative. From 2003/04 to 2004/05, Nganampa Health Council received a total of $214,000. From 2004/05 to 2005/06, Durri Aboriginal Medical Service (the third and final site) received a total of $290,000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-334

OUTCOME 7: Indigenous Health

Topic: EYE HEALTH

Written Question on Notice

Senator Crossin asked:

Please provide information on the geographic location of Eye Health Co-ordinators and the number of positions.

Answer:

There are 34 full time equivalent Eye Health Co-ordinator positions funded by the Office for Aboriginal and Torres Strait Islander Health (OATSIH). These positions are located at:

State	Geographic Location
New South Wales	Bourke, Kempsey, Broken Hill, Narooma, Wagga Wagga, Walgett and Wellington
South Australia	Port Augusta, Port Lincoln, Ceduna, Yalata, Oak Valley, Coober Pedy, Anangu Pitjantjatjara Yankunytjatjara (APY) Lands. There is also a position that provides services across the entire State.
Queensland	Brisbane, Rockhampton, Townsville, Cairns/Cape York, Torres Strait and North Peninsula Area, Mount Isa and Charleville
Victoria	Loddon Mallee and Hume regions and the Western Region
Northern Territory	Alice Springs, Barkly, Darwin, East Arnhem Land and Katherine
Western Australia	Goldfields/Central Desert, Kimberley, Midwest/Gascoyne, Pilbara and the South West regions

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-335

OUTCOME 7: Indigenous Health

Topic: EYE HEALTH

Written Question on Notice

Senator Crossin asked:

Please provide a copy of the latest report from the Eye Health Co-ordinators. Is this still done on a biannual basis?

Answer:

The Eye Health Co-ordinator Output Indicator Reports are no longer available. During the Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program, Regional Eye Health Coordinators were no longer required to provide separate reports.

Reporting requirements are now captured within the Service Development Reporting Framework (SDRF) reports. The SDRF encompasses the development of, and reporting against, Action Plans at the service level.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-337

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH

Written Question on Notice

Senator Crossin asked:

How many Aboriginal Health Workers are there on CDEP? Can you provide a breakdown by state and territory?

Answer:

The table below shows the number of full time equivalent Aboriginal Health Worker (AHW) positions funded by the Community Development Employment Program (CDEP) by state and territory for 2003-04.

State/Territory	**Full time equivalent AHW funded by CDEP 2003-04**
NSW/ACT	0.6
Victoria	4.7
Queensland	0
South Australia	0
Western Australia	4.05
Northern Territory	5.4
Tasmania	0
Total	**14.75**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-340

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH – NATIONAL DRUG STRATEGY

Written Question on Notice

Senator Crossin asked:

(a) What funds have been expended and what future funds have been allocated to implement the National Drug Strategy for Aboriginal and Torres Strait Islander Peoples Complementary Action Plan 2003-2006?
(b) Is the Department planning an evaluation of this plan? If so please provide details of this.

Answer:

(a) The Complementary Action Plan was developed to complement the issues raised in the National Drug Strategy and make them more applicable to Aboriginal and Torres Strait Islander peoples. The Ministerial Council on Drug Strategy (MCDS), a committee including Australian, State and Territory Government justice and health ministers, has identified a number of priority areas of activity. Funding in support of all of these activities is shared by the Australian Government and all jurisdictions. The purpose of the Complementary Action Plan is to provide guidance on Indigenous issues when developing programs across health and other sectors. Therefore, determination of a figure directed towards the Complementary Action Plan is unable to be identified.

(b) It would be a matter for consideration by the MCDS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-049

OUTCOME 7: Indigenous Health

Topic: PETROL SNIFFING EXPENDITURE

Written Question on Notice

Senator Evans asked:

The Combating Petrol Sniffing measure, which provided a total of $9.6 million over the next four year period, included:

a) $2.7m for communication and support. What is "communication and support"? How is that different from Departmental costs? Is that not Departmental costs?
b) $700 000 for improved data collection and reporting on prevalence.
   i) provide a specific breakdown on how the Department anticipates that will be spent?
   ii) What data is being collected to date? Specifically:
      1. Number of seriously disabled from PS?
      2. Number of petrol sniffers in Central Australia?
      3. Cost of health care for disabled person?
      4. Number of petrol-sniffing related deaths?
      5. Identify which statistics have been collected and attach any statistical information gathered to date.
   iii) $400 000 for evaluation to inform further action: Specify what this measure will achieve? Please provide a specific breakdown of how the Department anticipates this will be spent.

Answer:

a) These resources will be used to implement a Communication Strategy. It is expected this will include information kits, media production and delivery, training for community and family workers, provision of qualified expert assistance, mentoring, regional promotional campaigns and regional workshops to support communities registered on the Comgas Scheme and/or experiencing petrol sniffing issues. Departmental expenditure is primarily for costs such as human resources engaged by the Department of Health and Ageing to implement the overall petrol sniffing measure.

b) Currently there is very limited data in relation to the prevalence of petrol sniffing in communities. In order to better inform policy and forward planning a data collection and analysis system will be implemented.

i) Spending over four years is expected to be:

- 2005/06 – $204,000 for agreeing data parameters and definitions, establishing the data and reporting reference group, training data collectors, developing the system for collection, collation and analysis of data, and production and distribution of reports.
- 2006/07 – $183,000 to support data and reporting reference group meetings, refinement of the data collection, collation and analysis process, collection, collation and analysis of data, and production and distribution of reports.
- 2007/08 – $139,000 to support data and reporting reference group meetings, collection, collation and analysis of data, and production and distribution of reports.
- 2008/09 – $142,000 to support data and reporting reference group meetings, collection, collation and analysis of data, and production and distribution of reports.

ii) There is currently no national data available on petrol sniffing in remote areas. Some data is being collected at the jurisdictional level, but this is highly variable in scope and quality.

1 & 3: The Northern Territory Parliament's Select Committee on Substance Abuse in the Community noted earlier this year that:

> "The direct impact of inhalant abuse is usually contained to the sniffer and family and immediate community. However, it has implications for the broader community also. The end result of petrol sniffing other than early death is brain damage which leaves the sniffer in a vegetative state. A conservative estimate of the cost to the Northern Territory (NT) of maintaining an ex-sniffer in this state is $160,000 per annum. While there are presently 15 such persons in central Australia, it is estimated that this could escalate to upwards of 60 in the near future, an ongoing (and growing) cost of $9 millon per annum."

2: It is not possible to provide exact numbers of petrol sniffers who are classed as having a serious sniffing habit in the central region. The most comprehensive data set is managed by the Nganampa Health Council. The 2004 survey of prevalence of petrol sniffing on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands showed that:

- over 14% of the population (222 individuals) on the APY Lands between the ages of 10-40 sniff petrol; and
- of those who sniff petrol, the largest group is 15-24 year olds, with 115 total users or 52% of petrol sniffers.

In addition, submissions to the Northern Territory Coronial Inquests indicated that there are some 500 sniffers in the southern part of the NT, bringing the total number of sniffers in the cross border region (NT, South Australia (SA) and Western Australia (WA)) to around 700.

4: The 2004 Evaluation of the Comgas Scheme reported 37 deaths from petrol sniffing, between 1999-2003, in SA, WA, and the NT. Unpublished ABS data reports there were 19 deaths registered in Australia for the period 1997-2003 where toxic effects of petroleum products was mentioned. Of these ten were identified as Indigenous with six from the NT. In a report in *The Australian* of 10 August 2005, forensic pathologist Dr Terry Sinton 'told the inquiry that between 50-60 people in the Territory had died in the past eight years as a result of petrol sniffing… Dr Sinton said about 10 per cent of the deaths were directly related to petrol sniffing'.

5: In addition to the statistics above, the National hospitals data collections show that in 2003-04:

- there were 28 hospitalisations for Indigenous Australians with a *principle* diagnosis of toxic effects of petrol; and
- there were 40 hospitalisations for Indigenous Australians with *any* diagnosis of toxic effects of petrol.

iii) Through a tender process, an evaluation team will be established to implement an ongoing Evaluation of the Comgas Scheme as communities and regions roll out the new fuel. Sentinel sites will be established, through negotiation with participating communities. The evaluation will identify the range of factors that determine success and failure, what influences sniffers to start and stop sniffing and differences between participating and non-participating communities that either support or mitigate against the aims of the Comgas Scheme.

The proposed spending for successive years is:

- 2005/06 - $130,000 for evaluation reference group meetings, developing evaluation protocols, conducting the survey, collating the results, and production and distribution of the evaluation report.
- 2006/07 - $133,000 for evaluation reference group meetings, refining the evaluation survey, conducting the survey and collating the results, and production and distribution of the evaluation report.
- 2007/08 – $52,000 for evaluation reference group meetings, conducting the survey and collating the results, and production and distribution of the evaluation report.
- 2008/09 - $53,000 for evaluation reference group meetings, conducting the survey and collating the results, and production and distribution of the evaluation report.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-057

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

How much will be spent on the Anangu-Pitjantjatjarra COAG trial in 2005-06 by the Health Dept? Provide a breakdown for departmental and administered funds? How much have other departments spent on this particular trial?

Answer:

The Department of Health and Ageing has allocated $1,027,701 to the COAG trial in 2005-06. A specific breakdown of these funds is as follows:

Administered Funds

Activity	**Estimated Expenditure 2005-06 $ (GST incl)**
Administered Funds	873,701
Departmental Funds*	154,000

*Departmental funds expenditure is for those officers working exclusively on the Anangu-Pitjantjantjara COAG trial and an estimate of additional time contributed by other officers.

Updated expenditure figures from other departments are still being compiled and will be provided as soon as they are available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Revised Question: E05-057

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

How much will be spent on the Anangu-Pitjantjatjara COAG trial in 2005-06 by the Health Dept? Provide a breakdown for departmental and administered funds? How much have other departments spent on this particular trial?

Answer:

The Department of Health and Ageing has allocated $1,424,812 to the COAG trial in 2005/06. A breakdown of these funds is as follows:

Administered Funds

Activity	**2005-06 Allocation (GST incl)**
Administered Funds *	1,270,812
Departmental Funds**	154,000

* An increase on the November 2005 figure as it now includes anticipated expenditure on the construction of a pool at Watarru

**Departmental funds expenditure is for those officers working exclusively on the Anangu-Pitjantjatjara COAG trial and an estimate of additional time contributed by other officers.

The Office for Indigenous Policy Coordination (OPIC) has developed a database for financial and program descriptive data at a high level. The collection of more detailed information on funding from various agencies, including on a regional basis, is under review and will be subject to the availability of resources in OIPC and the agencies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Amended Revised Question: E05-057

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTJATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

How much will be spent on the Anangu-Pitjantjatjara COAG trial in 2005-06 by the Health Dept? Provide a breakdown for departmental and administered funds? How much have other departments spent on this particular trial?

Answer:

The Department of Health and Ageing has allocated $1,253,745 to the COAG trial in 2005/06. A breakdown of these funds is as follows:

Administered Funds

Activity	**2005-06 Allocation (GST incl)**
Administered Funds *	1,099,745
Departmental Funds**	154,000

* A change on the November 2005 figure as it now includes anticipated additional expenditure on the construction of a pool at Watarru and reduced estimate of other project funding.

**Departmental funds expenditure is for those officers working exclusively on the Anangu-Pitjantjatjara COAG trial and an estimate of additional time contributed by other officers.

The Office for Indigenous Policy Coordination (OPIC) has developed a database for financial and program descriptive data at a high level. The collection of more detailed information on funding from various agencies, including on a regional basis, is under review and will be subject to the availability of resources in OIPC and the agencies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-294

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice and Hansard page CA 126

Senator Crossin asked:

How many people are there with a known serious petrol sniffing habit in Indigenous Communities in Central Australia?

Answer:

There is no national data available on petrol sniffing. The most comprehensive data set is managed by the Nganampa Health Council, whose 2004 survey of prevalence of petrol sniffing on Anangu Pitjantjatjara Yankunytjatjara (APY) Lands showed that:

- over 14% of the population (222 individuals) on the APY Lands between the ages of 10-40 sniff petrol; and
- of those who sniff petrol, the largest group is 15-24 year olds, with 115 total users or 52% of petrol sniffers.

In addition, submissions to the Northern Territory Coronial Inquests indicated that there are some 500 sniffers in the southern part of the Northern Territory (NT), bringing the total estimated number of sniffers in the cross border region (NT, South Australia and Western Australia) to around 700.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-336

OUTCOME 7: Indigenous Health

Topic: EYE HEALTH

Written Question on Notice

Senator Crossin asked:

(a) What was the budgeted amount for 2004/05 and for 2005/06 for Eye Health?
(b) Were there any unexpended funds in 2004/05? If so how much was this and why were they not spent?

Answer:

(a) The Eye Health budget allocation was $2.70 million in 2004/05 and $2.60 million in 2005/06.

(b) There was an underspend of $0.128 million in 2004-05 of the allocated eye health budget. This occurred because:
- a Contractor was not engaged in 2004-05 for the national eye health equipment stock-take, as the selected Contractor became unavailable. A second tender process was conducted and a Contractor was engaged in 2005-06;
- the last performance criteria for the eye health specialist access project in South Australia was not achieved until early 2005-06, which delayed the final payment; and the
- implementation of the Australian Government Response to the Review of the Program was progressed on a State and Territory basis rather than at the national level.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-338

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

Can you provide the year to date 2004/05 and 2005/06 expenditure on PHCAP by specific sites in an update of table E03-106?

Answer:

2004 – 05 PHCAP Expense

State	OATSIH Planning Region	$ million
ACT	ACT	0.03
ACT Total		0.03
NAT	National	0.24
	Statewide	0.05
NAT Total		0.29
NSW	Central Coast	0.28
	Far West	1.00
	Greater Murray	0.41
	Hunter	0.11
	Illawarra	0.11
	Macquarie	0.21
	Mid North Coast	0.18
	Mid-Western	0.98
	New England	1.27
	Northern Rivers	0.61
	SE Sydney	0.08
	Southern	0.05
	Sydney Central	0.74
	W Sydney	0.02
NSW Total		6.06

NT	Central Australia	0.37
	Darwin	0.49
	Katherine East	0.30
	Katherine West	2.66
	Maningrida	0.08
	North East Arnhem	0.15
	Northern Barkly	0.31
	NT Wide	0.88
	Pitjantijatjara	0.06
	South East Top End	0.12
	Statewide	3.40
	Tiwi	1.13
	Top End West	0.26
	Warlpiri	1.06
	West Arnhem	0.09
	Alice Springs	0.05
	South Barkly	0.04
NT Total		11.44
QLD	Atherton	0.09
	Brisbane North	0.12
	Brisbane S&E	0.94
	Bundaberg	0.02
	Cairns	1.12
	Central Highlands	0.90
	Central West	0.04
	Far South West	0.02
	Gladstone	0.01
	Gulf	0.11
	Hinchinbrook	0.03
	Ipswich & West Moreton	0.03
	Mt Isa	2.00
	Near South West	0.61
	North West Darling Downs	1.68
	NW Darling Downs	0.10
	Rockhampton	0.81
	South Coast and Hinterland	0.02
	Statewide	0.24
	Sunshine Coast and Cooloola	0.03
	Torres	1.16
	Townsville	0.11
QLD Total		10.18
SA	Eyre	0.09
	Hills Mallee Southern	0.52
	Metropolitan	1.80
	Mid North	0.30
	Northern and Far Western	0.79
	Riverland	0.21
	South East	0.17
	Wakefield	0.48
SA Total		4.35
TAS	Northern	0.43
	Northern Western	0.04
	Southern	0.26
TAS Total		0.73

VIC	Barwon South West	0.86
	Gippsland	0.09
	Grampians	0.09
	Hume	0.59
	Loddon Mallee	0.28
	Metropolitan	0.70
VIC Total		2.61
WA	Goldfields	0.04
	Kimberley	5.64
	MidWest	0.01
	Ngaanyatjarraku	0.35
	Pilbara	0.39
	South East Metro	0.02
	South West	0.86
	South West Metro	0.51
	Statewide	0.02
	Wheatbelt	0.11
WA Total		7.93
Grand Total		**43.62**

Given delays in the signature of service contracts a more meaningful date for reporting on PHCAP expenditure for 2005-2006 would be 30 December 2005. Figures for 2005-2006 will be provided when available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Revised Question: E05-338

OUTCOME 7: Indigenous Health

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM (PHCAP)

Written Question on Notice

Senator Crossin asked:

Can you provide the year to date 2004/05 and 2005/06 expenditure on PHCAP by specific sites in an update of table E03-106?

Answer:

2004–05 PHCAP Expenditure

State	OATSIH Planning Region	$m
ACT	ACT	0.03
ACT Total		0.03
NAT	National	0.24
	Statewide	0.05
NAT Total		0.29
NSW	Central Coast	0.28
	Far West	1.00
	Greater Murray	0.41
	Hunter	0.11
	Illawarra	0.11
	Macquarie	0.21
	Mid North Coast	0.18
	Mid-Western	0.98
	New England	1.27
	Northern Rivers	0.61
	SE Sydney	0.08
	Southern	0.05
	Sydney Central	0.74
	W Sydney	0.02
NSW Total		6.06
NT	Central Australia	0.37
	Darwin	0.49
	Katherine East	0.30
	Katherine West	2.66
	Maningrida	0.08
	North East Arnhem	0.15

	Northern Barkly	0.31
	NT Wide	0.88
	Pitjantijatjara	0.06
	South East Top End	0.12
	Statewide	3.40
	Tiwi	1.13
	Top End West	0.26
	Warlpiri	1.06
	West Arnhem	0.09
	Alice Springs	0.05
	South Barkly	0.04
NT Total		11.44
QLD	Atherton	0.09
	Brisbane North	0.12
	Brisbane S&E	0.94
	Bundaberg	0.02
	Cairns	1.12
	Central Highlands	0.90
	Central West	0.04
	Far South West	0.02
	Gladstone	0.01
	Gulf	0.11
	Hinchinbrook	0.03
	Ipswich & West Moreton	0.03
	Mt Isa	2.00
	Near South West	0.61
	North West Darling Downs	1.68
	NW Darling Downs	0.10
	Rockhampton	0.81
	South Coast and Hinterland	0.02
	Statewide	0.24
	Sunshine Coast and Cooloola	0.03
	Torres	1.16
	Townsville	0.11
QLD Total		10.18
SA	Eyre	0.09
	Hills Mallee Southern	0.52
	Metropolitan	1.80
	Mid North	0.30
	Northern and Far Western	0.79
	Riverland	0.21
	South East	0.17
	Wakefield	0.48
SA Total		4.35
TAS	Northern	0.43
	Northern Western	0.04
	Southern	0.26
TAS Total		0.73
VIC	Barwon South West	0.86
	Gippsland	0.09
	Grampians	0.09
	Hume	0.59
	Loddon Mallee	0.28
	Metropolitan	0.70
VIC		2.61

Total		
WA	Goldfields	0.04
	Kimberley	5.64
	MidWest	0.01
	Ngaanyatjarraku	0.35
	Pilbara	0.39
	South East Metro	0.02
	South West	0.86
	South West Metro	0.51
	Statewide	0.02
	Wheatbelt	0.11
WA Total		7.93
Grand Total		**43.62**

2005–06 PHCAP Expenditure

State	OATSIH Planning Region	$m
ACT	ACT	0.07
ACT Total		**0.07**
NSW	Far West	0.74
	Greater Murray	0.24
	Hunter	0.19
	Macquarie	0.28
	Metropolitan	0.01
	Mid Western	0.73
	New England	0.93
	Northern Rivers	0.62
	Western Sydney	0.05
NSW Total		**3.78**
NT	Anmatjere	0.69
	Barkly Region/ South Barkly	0.20
	Darwin	0.28
	Eastern Arrente-Alyawarra	0.46
	Katherine West	1.98
	Luritja-Pintupi	0.24
	Maningrida	0.18
	Northern Barkly	0.23
	NT Wide	0.07
	Pitjantijatjara	0.07
	South East Arnhem	0.08
	Top End West	0.53
	Warlpiri	0.61
NT Total		**5.64**
QLD	Atherton	0.08
	Brisbane North	0.04
	Brisbane South & East	0.06
	Bundaberg	0.02
	Cairns	0.85
	Central Highlands	0.16
	Central West	0.06
	Gladstone	0.02

	Gulf	0.06
	Hinchinbrook	0.04
	Ipswich & West Moreton	0.06
	Mt Isa	1.46
QLD cont'	Near South West	0.55
	North West Darling Downs	0.49
	Rockhampton	0.63
	South Coast & Hinterland	0.05
	Statewide	1.09
	Sunshine Coast & Cooloola	0.03
	Torres	0.25
	Townsville	0.06
QLD Total		**6.06**
SA	Eyre	0.07
	Hills Mallee Southern	0.40
	Metropolitan	1.32
	Mid North	0.18
	Riverland	0.16
	South East	0.11
	Wakefield	0.36
	Northern & Far Western	0.79
SA Total		**3.39**
TAS	Northern	0.33
	Northern Western	0.11
	Southern	0.16
TAS Total		**0.60**
VIC	Barwon South West	0.27
	Grampians	0.08
	Hume	0.40
	Loddon Mallee	0.09
	Metropolitan	0.30
VIC Total		**1.14**
WA	Goldfields	0.11
	Kimberley	2.28
	Midwest	0.01
	Ngaanyatjarraku	0.16
	Pilbara	0.42
	South East Metro	0.06
	South West Metro	0.43
	Statewide	0.07
WA Total		**3.53**
Grand Total		**24.20**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-285

OUTCOME 7: Indigenous Health

Topic: MBS AND PBS SPENDING ON THE INDIGENOUS POPULATION

Written Question on Notice

Senator Crossin asked:

> Do the figures of the Medical Benefits Scheme (MBS) and Pharmaceutical Benefits Scheme (PBS) spending on the Indigenous population include the money that is spent through Primary Health Care Access Program (PHCAP) and the S100 Medicines Program and provided through community controlled health services? If not, what do we know about that expenditure?

Answer:

> The figures in the *Expenditures on health for Aboriginal and Torres Strait Islander people 2001-02* under the MBS (Table 4.1, page 21) do not include PHCAP funding. The figures under the PBS (Table 4.1, page 21) do include expenditure under section 100. Table 4.1, page 21 provides detail of Australian Government expenditure across all categories of Indigenous health including:
>
> Medical services ($182.58 per Indigenous person) which comprises:
> - mainstream Medicare medical service payments;
> - other Health and Ageing portfolio programs; and
> - Department of Veterans' Affairs medical services.
>
> Pharmaceuticals ($78.30 per Indigenous person) which comprises:
> - mainstream PBS and the Repatriation Pharmaceutical Benefits Scheme payments and the special pharmaceutical supply arrangements in remote Aboriginal Health Services (under s100 of the *National Health Act 1953*); and
> - other Pharmaceuticals (from the enhanced rural and remote pharmacy package).
>
> Community health services ($363.81 per Indigenous person) which comprises:
> - Office of Aboriginal and Torres Strait Islander Health funding to Aboriginal Controlled Community Health Services, including PHCAP funding;
> - Medicare medical service payments through s19(2) (of the *Health Insurance Act 1973*);
> - Bush nursing;
> - Mental health ‘More options, better outcomes’; and
> - Rural nursing initiatives.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-291

OUTCOME 7: Indigenous Health

Topic: ROLL-OUT OF OPAL FUEL

Written Question on Notice

Senator Crossin asked:

How many central Australian communities will this roll-out cover?

Answer:

It is proposed that the roll-out to the Australian Government's designated central desert region will cover an additional six remote Aboriginal and Torres Strait Islander communities, seven roadhouses and up to nine private pastoral properties.

The six communities to be covered by the rollout to the central desert area are: Kutjuta, Mutitjulu, Marla, Mintabie, Kalka and Yunyarinyi. Opal fuel will be located in Kalka and Yunyarinyi, which are the only two communities in this region which have infrastructure to supply fuel.

The seven roadhouses are: Mount Ebanezer, Curtin Springs, Wallara, Erlunda, Kulgera, Marla and Yulara.

Negotiations are underway to identify all of the pastoral properties in the region.

In addition, Opal fuel will be available at one service station in Alice Springs. This will allow for local residents to purchase non-sniffable fuel and for tourists and visitors who are entering the central desert region to fuel up on non-sniffable fuel prior to undertaking travel into this region.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-281

OUTCOME 8: Private Health

Topic: ANCILLARY BENEFITS

Hansard Page: CA 90

Senator Forshaw asked:

Would you give me some information on notice about how you determine the level of refund? What scale of prices would you have regard to? What is the way in which you would determine the percentage you would pay back?

Answer:

Benefits for individual items under ancillary tables are calculated according to a range of criteria including consumer demand and expectations, clinical effectiveness, and the level of financial risk to Medibank Private. In addition, ancillary benefits are subject to maximum annual limits specified under the particular cover held by the member.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-204

OUTCOME 8: Private Health

Topic: PORTABILITY REVIEW

Written Question on Notice

Senator McLucas asked:

With reference to the Department's PHI circular of the 29 August 2005, reference PHI 45/05 titled: "Condition of Registration – Portability"

a) Can the Department confirm that this circular is the result of recent work – as discussed at the May Budget Estimates, on addressing concerns about the effect of benefit limitations on portability?
b) Who has been involved in this work? Who has the department consulted with?
c) Is there agreement with all private health funds?
d) What about those funds which had applied benefit limitations? What has been there [sic] response to this announcement?

Answer:

a) Yes.
b) The department sought comments on a draft condition via circular PHI 45/05. Circulars are emailed to a large number of industry and other stakeholders, and are also publicly available on the department's website. In addition, the department wrote separately to the Australian Health Insurance Association; the Health Insurance Restricted Membership Association of Australia; the Australian Private Hospitals Association; Catholic Health Australia; the Australian Medical Association; the Private Health Insurance Ombudsman; the Private Health Insurance Administration Council; Consumers' Health Forum; the Strategic Planning Group for Private Psychiatric Services; the Mental Health Council of Australia; and beyondblue.
c) Agreement of health funds to the imposition of a Condition of Registration is not required.
d) All health funds are required to comply with the Condition.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-205

OUTCOME 8: Private Health

Topic: PORTABILITY REVIEW

Written Question on Notice

Senator McLucas asked:

With reference to the Department's PHI circular of the 29 August 2005, reference PHI 45/05 titled: "Condition of Registration – Portability"

a) When will this new condition of registration come into effect; that is when will health funds have to operate under this new condition?

b) Why was the start date postponed from 1 October to 1 November 2005?

Answer:

a) 1 December 2005.

b) The 1 October date to which Circular PHI 45/05 referred was not the proposed "start date" but the date by which health funds would be required to notify affected contributors. Circular PHI 45/05 and letters to stakeholders asked for submissions by 9 September 2005. Several submissions were received after this date, up to 15 September 2005. The department considered that there was insufficient time to consider all submissions and provide further advice to the Minister; for the Minister to consider that advice; and for health funds to prepare and dispatch correspondence to affected contributors, before the proposed 1 October notification date.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-206

OUTCOME 8: Private Health

Topic: PORTABILITY REVIEW

Written Question on Notice

Senator McLucas asked:

With reference to the Department's PHI circular of the 29 August 2005, reference PHI 45/05 titled: "Condition of Registration – Portability"

a) Does the Department have any information on how many people – ie. policy holders – this new condition will effect?

b) How long has the Department been working on addressing this issue?

Answer:

a) The department is aware of two health funds that apply benefit limitation periods to transferring members, but does not have information on the number of people affected.

b) The Condition of Registration has been under development since June 2005 and the subject of confidential stakeholder consultation. It came into effect on 1 December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-207

OUTCOME 8: Private Health

Topic: PORTABILITY REVIEW

Written Question on Notice

Senator McLucas asked:

With reference to the Department's PHI circular of the 29 August 2005, reference PHI 45/05 titled: "Condition of Registration – Portability"

a) Isn't it true that this issue first emerged when Australian Unity applied benefit limitations to their policies – in the first half of 2004?
b) Why has it taken so long to act on this issue and its impact on portability?
c) Doesn't this effectively mean that many consumers have had these limitations applied during the long period it has taken for the department to act?

Answer:

a) Yes.
b) Portability is a complex issue and any policy change must be considered in the light of its implications for consumers, health funds and private hospitals.
c) To the extent that a health fund imposed a benefit limitation period, and it had not expired or been removed, it will have continued to apply. While the department does not have information on the number of people affected, as far as the department is aware only two funds have routinely applied benefit limitation periods to transferring members. Therefore the number of affected consumers is not large.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-208

OUTCOME 8: Private Health

Topic: PORTABILITY REVIEW

Written Question on Notice

Senator McLucas asked:

What other work is the department doing to ensure that portability is protected and that legislation keeps up with current and future challenges?

Answer:

The department continues to consider policy and legislative issues, to consult with stakeholders and to provide considered and reliable advice to the Minister.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-209

OUTCOME 8: Private Health

Topic: REVIEWS OF REINSURANCE AND LOYALTY BONUS

Written Question on Notice

Senator Jan McLucas asked:

a) Where is work up to in the review of reinsurance?

b) Why has the department again deferred the review?

Answer:

a) The Government recently reconsidered the proposed reinsurance arrangements which were due to commence in July 2006. The Government has decided to defer changing the existing reinsurance arrangements to enable a review of possible risk equalisation options to be considered having regard to the current and future operations of health funds.

   An open tender process was conducted to appoint a consultant to review the risk equalisation options. Ernst & Young Pty Ltd was the successful consultant. The consultant started work on 14 November 2005. The consultancy assessed a range of risk equalisation models, including those already proposed by industry, and make recommendations about possible risk equalisation scheme options that will sustain private health insurance now and into the future.

b) See answer (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-300

OUTCOME 8: Private Health

Topic: REVIEWS OF REINSURANCE AND LOYALTY BONUS

Written Question on Notice

Senator Jan McLucas asked:

a) Why has the department gone out to tender for work on these models – haven't alternative models already been developed in consultation with industry?

b) How much has the department budgeted for this tender process and the resulting consultancy?

c) How much longer will this process take?

Answer:

a) The Government decided to defer changing the existing reinsurance arrangements to allow a review to be conducted of the risk equalisation models that had been suggested, including those proposed by industry.

b) The consultancy contract awarded to Ernst & Young ABC Pty Ltd is for $104,500 (GST inclusive).

c) A final report on risk equalisation options was provided to the department in December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-301

OUTCOME 8: Private Health

Topic: REVIEWS OF REINSURANCE AND LOYALTY BONUS

Written Question on Notice

Senator Jan McLucas asked:

> How could changes in reinsurance effect the PHI market and the types of products it offers to consumers?

Answer:

> It is not possible to anticipate the impact of changes to reinsurance until the possible options for change have been proposed and evaluated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-302

OUTCOME 8: Private Health

Topic: REVIEWS OF REINUSRANCE AND LOYALTY BONUS

Written Question on Notice

Senator McLucas asked:

a) Where is the review of Loyalty bonus schemes at? (Reference – circular of the 16 February 2005 PHI 07/05)
b) Who has made submissions to the review?
c) What sort of options have been canvassed?
d) What when [sic] this review be completed?
e) What sort of impact could changes in this area have on the PHI market and the sorts of products it offers?

Answer:

a) A report was provided to the Minister on 5 June 2005.
b) Submissions were received from the Australian Health Insurance Association; the Health Insurance Restricted Membership Association of Australia; Brent Walker Actuarial Services; the Private Health Insurance Administration Council; and the following health funds: Medibank Private; BUPA Australia Health Pty Ltd; GMHBA Ltd; HBF ; and MBF.
c) The submissions canvassed a broad range of options, from no change to the present scheme to advocating measures to attract and retain younger, healthier members.
d) See answer to a) above.
e) It is not possible to anticipate the impact of changes in this area until the possible options for change have been evaluated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-303

OUTCOME 8: Private Health

Topic: REVIEWS OF REINSURANCE AND LOYALTY BONUS

Written Question on Notice

Senator Jan McLucas asked:

a) What interaction does the Department have with the Department of Finance on the sale of Medibank Private?

b) How often has the Department met with Finance on this issue – at any level?

c) Will the Department get to see a copy of the scoping study once completed?

Answer:

a) The department has met with the Department of Finance and Administration to discuss general issues relating to the update of the scoping study into the possible sale of Medibank Private.

b) The department has met with the Department of Finance and Administration to discuss the update of the scoping study into the possible sale of Medibank Private on four occasions since 1 July 2005.

c) The dissemination of the report about the update of the scoping study into the possible sale of Medibank Private is a matter for the Minister for Finance and Administration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-280

OUTCOME 8: Private Health

Topic: PODIATRIC SURGERY

Hansard Page: CA 85

Senator Humphries asked:

So do you expect that once that listing occurs there would be a full alignment as far as Medibank Private is concerned between services offered by podiatrists and orthopaedic surgeons?

Answer:

Yes, once Medicare Benefits Schedule listing of podiatric surgery procedures occurs there would be full alignment between podiatric and orthopaedic surgeons.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-282

OUTCOME 8: Private Health

Topic: Podiatric Surgery

Hansard Page: CA 89

Senator Humphries asked:

Is it still the intention of Medibank Private, once registration occurs, to have anaesthetist services for podiatric surgery covered? Is it still your intention to do that?

Answer:

Yes, once Medicare Benefits Schedule billing approval of surgical procedures performed by accredited podiatric surgeons occurs anaesthetic services for podiatric surgery will be covered.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-355

OUTCOME 8: Private Health

Topic: INSULIN PUMPS

Hansard Page: CA 90

Senator Barnett asked:

What is the policy of Medibank Private on covering insulin pumps?

Answer:

Medibank Private covers 100% of the cost of insulin pumps listed on the Government approved surgical prosthesis list for inpatient and outpatient procedures.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-210

OUTCOME 9: Health System Capacity and Quality

Topic: HEALTHCONNECT EXPENDITURE AND BUDGET 2004-05 TO 2008-09

Hansard Page: CA 133

Senator Polley asked:

a) What is the budget for Health*Connect* for 2004-05 through to 2008-09? Can you give that to me broken down by year?

b) How much of the 2004-05 appropriation was spent on evaluation studies?

c) How much of the 2004-05 appropriation was spent on pilot projects and trials?

Answer:

a) The budget for Health*Connect* for 2004-05 through to 2007-08 is $128.3 million. Health*Connect* is not funded for 2008-09. The financial year Health*Connect* funding for 2004-05 through to 2007-08 is as follows:

2004-05:	$32.6 million
2005-06:	$31.78 million
2006-07:	$31.51 million
2007-08:	$32.41 million

b) $222,576 of the 2004-05 appropriation was spent on evaluation studies.

c) $2,356,311 of the 2004-05 appropriation was spent on pilot projects and trials

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-222

OUTCOME 9: Health System Capacity and Quality

Topic: OVERSEAS TRAINED DOCTORS

Hansard Page: CA 130

Senator Polley asked:

a) In the 12 months to 30 June 2005, how many overseas trained doctors have come to Australia as a result of Australian Government recruitment efforts?

b) Could a breakdown be provided between GPs and specialists and information on their locations? What countries did these doctors come from? How many doctors have come out as a permanent resident?

Answer:

a) 184 overseas trained doctors were recruited in the period 1 July 2004 to 30 June 2005 under the international recruitment program of the Strengthening Medicare initiative.

b) 143 General Practitioners. 41 Specialists.

See Attachment A for placement information.

See Attachment B for country of origin information.

28 doctors have permanent residency. 156 doctors have temporary residency.

ATTACHMENT A

Recruited overseas trained doctors by location July 2004 – June 2005

	Location	Post Code	Number of Doctors
NSW	Broken Hill	2880	2
	Casino	2470	1
	Coffs Harbour	2450	1
	Cootamundra	2590	1
	Dubbo	2830	1
	Goulburn	2580	1
	Grafton	2460	1
	Inverell	2360	1
	Kanwal	2259	2
	Moree	2400	1
	Port Macquarie	2444	1
	Singleton	2330	1
	Tamworth	2340	2
	Taree	2430	1
	Wagga Wagga	2650	4
	Wollongong	2500	2
			23
NT	Alice Springs	0870	**1**
QLD	Bowen	4805	2
	Boyne Island	4680	1
	Burleigh Heads	4220	1
	Caboolture	4510	1
	Cairns	4870	2
	Caloundra	4551	2
	Capalaba	4157	1
	Carrara	4211	1
	Cherbourg	4605	1
	Currumbin Waters	4223	1
	Gin Gin	4671	1
	Gladstone	4680	4
	Herston	4029	3
	Jacobs Well	4208	1
	Kuranda	4872	1
	Longreach	4730	1
	Mackay	4740	5
	Malanda	4885	1
	Meadowbrook	4131	1
	Mount Isa	4825	1
	Nambour	4560	4
	Paradise Point	4216	1
	Pimlico	4812	1
	Rasmussen	4815	3
	Ravenshoe	4888	1
	Rockhampton	4700	1
	Springfield	4300	1
	Springfield Lakes	4300	1
	Townsville	4812	2

	Woodridge	4113	1
	Wulguru	4811	1
			49
SA	Adelaide	5107	1
	Ardrossan	5571	1
	Athelstone	5076	1
	Balaklava	5461	1
	Blackwood	5051	1
	Cooper Pedy	5723	2
	Craigmore	5114	1
	Gawler	5118	2
	Millicent	5280	2
	Moonta	5558	1
	Mount Gambier	5290	5
	Noarlunga Centre	5168	1
	Norwood	5071	3
	Port Augusta	5700	1
	Port Lincoln	5606	1
	Port Pirie	5540	1
	Renmark	5341	1
	Ridgehaven	5097	1
	Roxby Downs	5725	1
	Salisbury	5108	3
	Salisbury Downs	5108	1
	Seaford	5169	1
	Virginia	5120	2
	Whyalla	5600	1
	Woomera	5720	1
			37
TAS	Exeter	7275	1
	Hobart	7000	1
	Latrobe	7307	2
	Launceston	7250	1
	New Norfolk	7140	1
	Rosebery	7470	2
	Scottsdale	7260	2
	Wynyard	7325	1
			11
VIC	Ararat	3377	1
	Camperdown	3260	1
	Coleraine	3311	1
	Frankston	3199	1
	Geelong	3220	1
	Hastings	3915	1
	Kealba	3021	1
	Kyabram	3619	1
	Laylor	3075	1
	Leopold	3224	1
	Mildura	3500	1
	Nhill	3418	1
	Point Cook	3030	1
	Portland	3305	1

	Selby	3159	1
	Seymour	3660	1
	Shepparton	3630	1
	Traralgon	3844	1
	Yarrawonga	3730	1
			19
WA	Alexander Heights	6064	1
	Australind	6233	1
	Bunbury	6230	1
	Byford	6122	1
	Carnarvon	6701	2
	Derby	6728	1
	Esperance	6450	2
	Falcon	6210	1
	Forrestfield	6058	1
	Geraldton	6530	1
	Golden Bay	6174	1
	Gooseberry Hill	6076	2
	Harvey	6220	2
	Helena Valley	6056	1
	High Wycombe	6057	1
	Kalgoorlie	6430	2
	Kelmscott	6111	1
	Kununurra	6743	3
	Langford	6147	1
	Mandurah	6210	1
	Merriwa	6030	2
	Midland	6056	1
	Mindarie	6030	1
	Narrogin	6312	2
	Northam	6566	1
	Parmelia	6167	1
	Pemberton	6260	1
	Pinjarra	6208	1
	Port Kennedy	6172	1
	Quinns Rock	6030	1
	Roebourne	6718	1
	South Lake	6164	1
	Stratton	6056	1
	West Perth	6005	2
			44

ATTACHMENT B

Overseas Trained Doctors by country of origin July 2004 – June 2005

Country recruited from	
Australia*	**20**
Bahrain	**1**
Canada	**7**
China	**1**
Denmark	**1**
Egypt	**1**
Fiji	**3**
Germany	**9**
India	**23**
Iran	**2**
Ireland	**2**
Macedonia	**1**
Malaysia	**7**
Netherlands	**6**
New Zealand	**8**
Nigeria	**3**
Oman	**3**
Pakistan	**3**
Saudi Arabia	**2**
Singapore	**5**
South Africa	**35**
Sri Lanka	**3**
Swaziland	**3**
Switzerland	**1**
United Arab Emirates	**2**
United Kingdom	**23**
USA	**6**
Zimbabwe	**3**
	184

* The doctors listed as recruited from Australia are doctors which were residing in Australia at the time of recruitment. The majority (16) of these doctors are permanent residents.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-223

OUTCOME 9: Health System Capacity and Quality

Topic: OVERSEAS TRAINED DOCTORS

Hansard Page: CA 130

Senator Polley asked:

What is the name of the sponsored body that represents national recruitment agencies in the medical field? Please include information about its method of operation, principles and contact details.

Answer:

Australian Association of Medical Recruitment Agents (AAMRA).

As a special interest group under the auspices of the Recruitment and Consulting Services Association (RCSA), AAMRA aims to deliver outcomes in the medical recruitment industry which will enhance the recruitment and support arrangements for overseas trained doctors in Australia:

- accredits and monitors the performance of its members within the medical practitioner recruitment agencies in Australia;
- provides open and regular discussion between the medical practitioner recruitment industry and the department through formal and informal industry forums; and
- develops education and training packages for members, including weekly tutorials and specialist education and development programs. The training includes access to programs leading to Certificate and Diploma awards in recruitment and selection and a range of compliance training in medical recruitment.

The CEO of the RCSA is Ms Julie Mills. The contact details are:

PO Box 18028
Collins Street East, Melbourne, VIC 8003
Tel: +61 3 9663 0555
Fax: +61 3 9663 5099

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-224

OUTCOME 9: Health System Capacity and Quality

Topic: OVERSEAS TRAINED DOCTORS

Hansard Page: CA 131

Senator Polley asked:

Can you provide a list of the members of the overseas trained doctors taskforce and the reference group?

Answer:

The members of the Overseas Trained Doctors Taskforce are at Attachment A.
The members of the Overseas Trained Doctors Reference Group are at Attachment B.

ATTACHMENT A

MEMBERS OF THE OVERSEAS TRAINED DOCTORS TASKFORCE

The Overseas Trained Doctors Taskforce is a section of the Health Services Improvement Division of the Department of Health and Ageing. All the members of the Taskforce are public servants. At 18 November 2005, the members are:

Ms Natasha Cole (Director)
Ms Gemma Duffy (Director)
Ms Kath O'Brien
Ms Julie Burke
Ms Sharyn Downey
Ms Milan Krecak
Ms Tiffany Stevenson
Ms Ruth Maberley
Ms Kelly Taber
Mr Roger Harris
Ms Sally Warild

ATTACHMENT B

OVERSEAS TRAINED DOCTORS REFERENCE GROUP

The Department of Health and Ageing has established an Overseas Trained Doctors Reference Group to provide a forum for the dissemination of information and an opportunity to discuss issues that will inform policy development for the Overseas Trained Doctors initiatives under the Medicare package.

Members of the Reference Group include representatives from the following:-

- Association of International Medical Graduates of Australia and New Zealand
- Australian College of Rural and Remote Medicine
- Australian Department of Health and Ageing
- Australian Department of Immigration and Multicultural and Indigenous Affairs
- Australian Divisions of General Practice
- Australian Doctors Trained Overseas
- Association Australian Health Workforce Officials Committee
- Australian Local Government Association
- Australian Medical Association
- Australian Medical Council
- Australian Rural and Remote Workforce Agencies Group
- Committee of Deans of Australian Medical Schools
- Committee of Presidents of Medical Colleges
- Confederation of Postgraduate Medical Education Councils
- Consumers' Health Forum
- General Practice Education and Training
- National Rural Health Alliance
- Royal Australian College of General Practitioners
- Rural Doctors Association of Australia
- State and Territory Government health departments

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-213

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 52-53

Senator Moore asked:

What are the figures for funding allocated to various suicide prevention programs and what is the figure for MindMatters program?

Answer:

Since 1999 about $10 million annually has been allocated under the National Suicide Prevention Strategy. MindMatters was launched in 2000. Since that financial year, over $16 million has been allocated to the initiative.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-214

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 52-53

Senator Moore asked:

What is the program allocation for mental health – eg Youth Mental Health Foundation, promotions and prevention activities?

Answer:

National mental health program allocations are provided below:

Program	**Years funding allocated**	**Amount ($ millions)**
Australian Health Care Agreements	2003-2008	331
Commonwealth Own Purpose Outlays – National Reform activities	2003-2008	66
Better Outcomes in Mental Health Care	2004-05 to 2008-09	142.7
Youth Mental Health Foundation	2004-05 to 2008-09	69
National Depression Initiative *beyondblue*	2004-05 to 2008-09	39.6
Australian Network for Promotion, Prevention and Early Intervention for Mental Health	2003-2006	4
MindMatters	2005-06	3
National Suicide Prevention Strategy	Annually	10
National Mental Health Program	Annually	6

Please note only mental health specific programs are listed here.

Australian Government spending on mental health within the health portfolio also includes Medicare-funded psychiatrists and general practitioners, pharmaceuticals and private hospital subsidies. These are not included here.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-215

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50-62

Senator Moore asked:

How much funding was given to the "Not For Service" report for 2005/06?

Answer:

In 2005-06 $30,000 was provided to the Mental Health Council of Australia (MHCA) for a report on "the national learnings from State-based community forums", which became the "Not For Service" report.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-216

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50-62

Senator Moore asked:

Please provide the total Government direct and indirect expenditure on mental health in Australia on one page?

Answer:

Total Government direct and indirect expenditure on mental health in 2001-02 is shown in the table below, which is included in the Australian Government Submission to the Senate Inquiry into the Provision of Mental Health Services in Australia. Later data is not available at this stage.

Government direct and indirect expenditure on mental health in Australia, 2001–02

		$ Millions [d]
Australian Government		
Direct expenditure [a]	National Mental Health Strategy	94.2
	Medicare Benefits Schedule — psychiatrists	196.9
	Medicare Benefits Schedule — general practitioners	167.3
	Pharmaceutical Benefits Scheme	497.8
	Private health insurance rebates	37.7
	Department of Veterans' Affairs [e]	133.8
	Other	18.2
	Subtotal direct	1,145.8
Indirect expenditure [b, c]	National Suicide Prevention Strategy	9.8
	Income support payments	1,968.3
	Workforce participation programs	70.5
	DVA disability compensation payments	180.0
	Housing and accommodation programs	108.9
	Disability services	42.6
	Aged care residential and community services	1,258.5
	Home and community care	10.0
	Subtotal indirect	3,648.6
Total Australian Government		4,794.4
State and territory governments		
Direct expenditure [b]	New South Wales	562.6
	Victoria	477.8
	Queensland	310.9
	Western Australia	212.1
	South Australia	145.8
	Tasmania	44.3
	Australian Capital Territory	27.2
	Northern Territory	16.9
	Total states and territories	1,797.6
Total direct expenditure (Australian Government, states and territories)		2,943.4
Total indirect (Australian Government only)		3,648.6
	Total expenditure	6,592.0

a 'Direct expenditure' refers to expenditure dedicated to the provision of specialised mental health services and related activities. Source for data: National Mental Health Report 2004.

b 'Indirect expenditure' refers to the estimated costs to the Australian Government of providing other social, support and income security programs for people affected by mental illness. Estimates of indirect expenditure by states and territories are not available. Source for data: as provided by relevant Australian Government departments.

c Indirect expenditure estimates made by relevant Australian Government departments are based on best available data and are conservative. A range of related program areas where estimates that could not be made are excluded from totals. Estimates may change as more accurate data become available.

d Totals may not tally due to rounding error.

e DVA has revised estimated direct spending on mental health for 2001-02 to $126.8m. This correction was reflected in the National Mental Health Report 2005 which was published on 21 December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-217

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50-62

Senator Moore asked:

Can you please provide an itemized evaluation process on the Dr Pirkis process?

Answer:

- In 2003, the Program Evaluation Unit of the University of Melbourne (led by Dr Jane Pirkis, Senior Research Fellow), was contracted by the department to develop an evaluation framework for the Better Outcomes in Mental Health Care Program.

- Divisions of General Practice are required to evaluate services funded through the Better Outcomes in Mental Health Care Program after the first year of operation and to contribute service data to a national minimum dataset - a purpose designed database for aggregating national data from the projects.

- The University of Melbourne synthesises this data and provides periodic reports to the Australian Government. To date, the following evaluation reports have been accepted by the department:

    1. First Interim Evaluation Report, December 2003 – reported on the 15 Access to Allied Psychological Services projects funded in 2002. This report included an analysis of the models of service delivery being used, the uptake of the projects and the advantages and disadvantages of the projects.

    2. Second Interim Evaluation Report, July 2004 – reported on the 15 first round and 14 supplementary round projects funded. This report included an analysis of the models of service delivery being used, the uptake of the projects, the consumers who were accessing the projects, the types of services being delivered to consumers and the advantages and disadvantages of the projects.

    3. Third Interim Evaluation Report, February 2005 – reported findings from an Evaluation Forum conducted in September 2004 involving Divisional representatives from 18 projects, which focused on the benefits and barriers associated with various aspects of service delivery models.

4. Fourth Interim Evaluation Report, April 2005 – reported findings from the first, supplementary and second round of projects funded up to 30 June 2004. This report included an analysis of the lessons that have been learned from early experiences of the projects.

5. Fifth Interim Evaluation Report, June 2005 – reported findings from a survey of Divisions undertaken in June 2005 on the association between the model of service delivery and the level of consumer access to services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-218

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 60

Senator Moore asked:

A general practitioner is able to refer a patient for six sessions of psychological intervention by an allied health professional and then, after a review, they may allocate another six – up to 12 sessions. Why can't it just be up to 12 visits?

Answer:

Design of the Better Outcomes in Mental Health Care Program, including the number of sessions provided, is based on advice to the department by the Better Outcomes Implementation Advisory Group, which includes a number of clinicians as members. The requirement for a review by a GP after six sessions enables the GP to monitor progress and remain involved in the care of the patient.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-219

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50:

Senator Moore asked:

What is the number and cost of psychology services that have been funded through the Better Outcomes in Mental Health Care Program?

Answer:

According to the national minimum dataset for the Access to Allied Psychological Services component of the Better Outcomes in Mental Health Care Program, a total of 102,120 sessions with allied health professionals, including psychologists, were recorded for 26,444 consumers, up to November 2005.

The total budget allocation for the Access to Allied Psychological Services component of the Program from 2001-02 to 2004-05 was $24.9 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-220

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50

Senator Moore asked:

What is the estimated number of doctors who are hoping to take up the Better Outcomes training package and the level 2 training program in the next 2 to 3 years?

Answer:

Based on current trends, the number of additional general practitioners (GPs) who will complete Level 1 training under the Better Outcomes in Mental Health Care Program is about 150 each quarter and the number of GPs who will complete Level 2 training is about 50 per quarter.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-221

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50

Senator Moore asked:

Please provide a divisional breakdown of the doctors and the services that are being used and how the funding is being allocated?

Answer:

Table 1 (Attachment A) presents the number of GPs who were registered at Level 1 with the Better Outcomes Program and the total number of 3 Step Mental Health Processes claimed, by Division of General Practice (based on postcode of location of service delivery), from 1 July 2004 to 30 June 2005.

Table 2 (Attachment A) presents the number of GPs who were registered at Level 2 with the Better Outcomes Program and the total number of MBS items claimed for Focussed Psychological Strategies, by Division of General Practice (based on postcode of location of service delivery), from 1 July 2004 to 30 June 2005.

Funding to Divisions to operate the Access to Allied Psychological Services projects is allocated using the Outcomes Based Funding formula.

Table 2: Number of Level 2 Registered GPs and Medicare claims for Focussed Psychological Strategies, by Division of General Practice

Financial year 2004-2005

Division of General Practice (a)		Registered GPs who claimed a non referred attendance during the period (b) (c) (d)	Number of FPS services (e)
201	Central Sydney DGP	22	713
202	Eastern Sydney DGP	8	nfp
203	South Eastern Sydney DGP	nfp	nfp
204	Canterbury DGP	8	122
205	Bankstown GP Division	nfp	nfp
206	Western Sydney GP Support	15	1,230
208	The Northern Sydney DGP	5	nfp
209	St George District DGP	10	nfp
210	Liverpool DGP	7	0
211	Fairfield DGP	5	nfp
212	Hornsby Ku-Ring-Gai Ryde DGP	15	383
213	Manly Warringah DGP	13	94
214	Sutherland DGP	11	nfp
215	Macarthur DGP	9	746
216	Illawarra DGP	22	563
217	Hunter Urban DGP	8	166
218	Hunter Rural DGP	7	nfp
219	Central Coast DGP	5	nfp
221	South East NSW DGP	nfp	nfp
223	Hastings Macleay DGP	nfp	0
224	Mid North Coast DGP	4	nfp
225	Northern Rivers DGP	9	155
226	Tweed Valley DGP	nfp	0
227	New England DGP	nfp	0
228	Riverina DGP & PH	nfp	nfp
229	NSW Central West DGP	6	nfp
230	Dubbo/Plains DGP	nfp	nfp
231	Barwon DGP	nfp	nfp
232	Murrumbidgee DGP	nfp	nfp
235	Southern Highlands DGP	4	nfp
236	North West Slopes DGP	nfp	nfp
237	Nepean DGP	4	nfp
238	Blue Mountains DGP	12	nfp
240	Hawkesbury DGP	nfp	nfp
	New South Wales Divisions Total	***225***	***7,467***

301	Melbourne DGP	20	2,060
302	North-East Valley DGP	13	859
303	Inner Eastern Melbourne DGP	8	nfp
304	Southcity GP Services	9	nfp
305	Westgate DGP	4	nfp
306	Western Melbourne DGP	15	217
307	North West Melbourne DGP	17	886
308	Northern DGP	4	nfp
310	Whitehorse DGP	9	nfp
311	Greater South Eastern DGP	14	668
312	Monash DGP	5	nfp
313	Central Bayside DGP	12	nfp
314	Knox DGP	5	nfp
315	Dandenong & District DGP	4	40
316	Mornington Peninsula DGP	4	nfp
317	Geelong DGP	9	nfp
318	Central Highlands DGP	8	nfp
319	North East Victorian DGP	25	16
320	Eastern Ranges GP Assoc.	7	350
322	South Gippsland DGP	5	nfp
323	Central-West Gippsland DGP	6	nfp
324	Otway DGP	nfp	nfp
325	Ballarat & District DGP	9	13
326	The Bendigo and District DGP	nfp	nfp
327	Goulburn Valley DGP	5	nfp
328	East Gippsland DGP	12	215
329	The Border DGP	4	nfp
330	West Vic DGP	nfp	0
332	Mallee DGP	4	nfp
	Victoria Divisions Total	***227***	***7,621***
401	SEA-GP	13	52
402	Brisbane South DGP	6	nfp
404	Logan Area DGP	9	nfp
405	Brisbane North DGP	17	1,192
406	Gold Coast DGP	11	nfp
407	The Redcliffe Bribie Caboolture DGP	4	nfp
409	Toowoomba and District DGP	nfp	0
411	Mackay DGP	nfp	0
412	Townsville DGP	7	nfp
413	Cairns DGP	5	nfp
414	Southern Queensland Rural DGP	nfp	nfp
417	Far North Queensland Rural DGP	nfp	nfp
418	Sunshine Coast DGP	15	518
419	Capricornia DGP	6	nfp
420	Wide Bay DGP	nfp	nfp
	Queensland Divisions Total	***98***	***4,409***
501	Adelaide Western DGP	11	nfp
502	Adelaide Northern DGP	nfp	nfp
503	Adelaide North East DGP	9	310
504	Adelaide Central and Eastern DGP	19	908
505	Adelaide Southern DGP	19	769
506	The Barossa DGP	nfp	nfp
508	Mid North Div of Rural Medicine	4	nfp
509	Riverland DGP	4	nfp

510	Limestone Coast DGP	4	nfp
511	Eyre Peninsula DGP	nfp	0
512	Flinders and Far North DGP	nfp	0
513	Murray Mallee DGP	nfp	nfp
514	Adelaide Hills DGP	6	nfp
	South Australia Divisions Total	***79***	***3,341***
601	Perth & Hills DGP	17	nfp
602	Perth Central Coastal DGP	17	334
603	Osborne DGP	23	444
604	Canning DGP	12	nfp
605	Fremantle Regional DGP	14	nfp
606	Rockingham Kwinana DGP	6	nfp
607	Peel/South West DGP	10	nfp
609	Great Southern DGP	4	nfp
612	Mid West DGP	4	nfp
613	Greater Bunbury DGP	6	nfp
615	Central Wheatbelt DGP	nfp	nfp
	Western Australia Divisions Total	***108***	***1,360***
701	Southern Tasmanian DGP	10	nfp
702	GP North DGP	6	nfp
703	North West Tasmania DGP	17	nfp
	Tasmania Divisions Total	***33***	***791***
801	Top End DGP	nfp	nfp
802	Central Australian DPHC	nfp	nfp
	Northern Territory Divisions Total	***9***	***nfp***
222	***ACT DGP***	***13***	***nfp***
	All Divisions	***789***	***25,101***

Based on Date of service, including data processed to the end of July 2005
nfp = Not For Publication

(a)Division has been allocated based upon the GPs postcode where the service was provided. Where a GP provided services in more than one Division, then the GP and services are counted in each division where the services were provided.
(b)Restricting the GPs to those who did a non-referred attendance counts only those GPs who were active during the financial year.
(c)Mental Health Services can only be claimed by GPs who have completed the mental health Familiarisation Training and have the appropriate mental health skills as required by the General Practice Mental Health Standards Collaboration.
(d)Counts for GPs are not additive across Divisions or across States/Territories. Consequently, GPs are counted only once in the national total and only once in the total for a particular State or Territory.
(e)Focussed Psychological Strategies (FPS) = MBS Items (2721,2723,2725,2727).
The medical practitioner must provide the service in a general practice participating in the PIP or an accredited practice.

Reference: A20 Number of Services and Providers by Division : 23SEP05
Information and Analysis Section, Primary Care Division.
Department of Health and Ageing

Australian Government
Department of Health and Ageing

Mr Michael McKinnon
FOI Editor
The Australian
28 Mayne Road
BOWEN HILLS QLD 4001

Dear Mr McKinnon

Freedom of Information Request No: 025-0506 – Deep Vein Thrombosis Study Phase Two

I am writing to you to in response to your letter dated 16 August 2005 (your reference 69/05) in which you sought access under the *Freedom of Information Act 1982* (the FOI Act) to copies of documents arising from a consultancy noted in the purchasing and disposal gazette, namely:

Contract ID:	1479134
Reference:	4500025944
Date:	04 Feb 2005
Value:	$35,000
Description:	Advice and services regarding the risks associated with deep vein thrombosis (DVT) and air travel

I understand that you withdrew this request on 30 August 2005 following discussion and e-mail correspondence with Ms Joanne Challender, A/g Director, Secondary Uses of Data Policy Section. You were advised that no report had been produced and you agreed to withdraw the FOI request provided the Department was prepared to:

i) provide *The Australian* with 30 days notice if, and when, a final report is produced; or
ii) advise if a final report will not be produced.

I am writing to formally advise you that due to difficulties encountered with managing the privacy aspects of the data, a final report will not be produced. The Department has decided not to proceed with the contract at this time and has recently terminated the contract. I provide a brief overview of background material which is relevant to the Department's decision.

Background

In July 2001, the then Secretary of the Department, Mr Andrew Podger signed a Memorandum of Understanding (MOU) with the Australian Government Department of Transport and Regional Services (DOTRs) in relation to funding Phase One of a study to estimate the size of the risk of air travellers getting deep vein thrombosis (DVT). The proposal was to be conducted in two phases:

- Phase One looking at journeys of significant duration.
- Phase Two using actual time exposed.

Phase Two was to be conducted only if a positive effect was found in Phase One.

Phase One of the study was completed in 2003. Its findings were published in the British Medical Journal (BMJ), Volume 327 on 8 November 2003. The paper entitled: *Deep vein thrombosis and air travel: record linkage study* was published under the auspices of the Department, the Australian National University's (ANU), National Centre Epidemiology and Population Health (NCEPH) and the University of Western Australia's, School of Population Health. It indicated a link between venous thromboembolism and long haul flights.

As you are aware, in February 2005, the Department entered into a contract with a service provider for the provision of expert advice and services.

In progressing Phase Two of this study, the Department discovered that the Australian Government Department of Immigration and Multicultural and Indigenous Affairs (DIMIA) has updated their data management infrastructure. The new infrastructure, whilst better for their core business, did not support the particular data management activities needed for this study. Before Phase Two can be progressed the Department, in conjunction with DIMIA needs to develop an alternative method for handling of the records which meets privacy and legislative requirements. The Department will then need to seek approval through an ethics committee before progressing the study further.

As a consequence of these concerns, the Department has decided not to proceed with the study at this time and has recently terminated the contract whilst we examine the feasibility, appropriateness and cost of an alternative methodology for progressing this work. I hope this makes it clear that the cancellation of the contract is no reflection on the contracted service provider, and is simply a response to the need to be rigorous in the processes for using data to be certain that the privacy of individuals is never compromised.

I have noted your interest in the DVT study and it is on file that should Phase Two go ahead and if, and when, a subsequent final report is published *The Australian* is to be sent a copy.

Should you have any inquiries concerning this matter, please do not hesitate to contact me on (02) 6289 5430.

Yours sincerely,

Ms Julie Roediger
Assistant Secretary
Economic & Statistical Analysis Branch
Portfolio Strategies Division

September 2005

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-304

OUTCOME 10: Acute Care

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

(a): Can the Department provide a line by line breakdown of all medical indemnity measures since November 2001?
(b): For each of these measures, please provide the estimated costs and corresponding actual cost to date.

Answer:

a) A breakdown of all medical indemnity measures since November 2001 is detailed in the table below:

Budget context	Title of measure
2002-03 additional estimates	Medical indemnity insurance – assistance package
	Medical indemnity insurance – Incurred-but-not-reported levy
	Medical indemnity insurance – Incurred-but-not-reported scheme
	United Medical Protection (UMP)/Australasian Medical Insurance Ltd (AMIL) guarantee
2003-04 budget	Medical indemnity insurance framework – rural obstetricians
2003-04 additional estimates	Medical indemnity – extension of high cost claims scheme
	Medical indemnity – lowering high cost claims scheme (HCCS) threshold to $300,000[#]
	Medical indemnity – additional assistance for rural procedural GPs[#]
	Medical indemnity – premium support scheme[#]
	Medical indemnity subsidy scheme – extension
	Medical indemnity – incurred-but-not-reported indemnity scheme levy
	Medical indemnity – exceptional claims scheme
	Medical indemnity – changes to United Medical Protection (UMP) liability contributions[#]
	Medical indemnity – 2005 policy review working party[#]
	Medical indemnity policy review
	Medical indemnity – run-off reinsurance vehicle (RRV)[#]

2004-05 budget[#]	Medical indemnity – 2005 policy review working party
	Medical indemnity – additional assistance for rural procedural GPs
	Medical indemnity – changes to United Medical Protection (UMP) liability contributions
	Medical indemnity – high cost claims scheme threshold reduction
	Medical indemnity – premium support scheme
	Medical indemnity – run-off reinsurance vehicle
2004-05 additional estimates	Medical indemnity – run-off cover scheme

[#]These measures correspond to measures published in the department's 2003-04 Portfolio Additional Estimates Statements. They were republished in the 2004-05 budget because their costs were not reflected in the 2003-04 Mid-Year Economic and Fiscal Outlook (MYEFO).

b) Liabilities under the medical indemnity schemes are estimated on a per financial year basis. As such, the total administered cost for the medical indemnity package can only be provided as at 30 June 2005 rather than at the time of the question. Total administered costs are set out below:

	2002-03 $m	2003-04 $m	2004-05 $m	Total estimated costs to 30 June 2005 $m	Total actual costs to 30 June 2005 $m
Competitive Neutrality arrangements – increased revenue	-	-	-	**-**	**-**
High Cost Claims Scheme (HCCS)[†]	19.055	19.055	19.055	**57.165**	**57.165** [§]
Extension of High Cost Claims Scheme	-	14.210	21.315	**35.525**	**35.525** [§]
Lowering high cost claims scheme (HCCS) threshold to $300,000.	-	5.200	10.900	**16.100**	**16.100** [§]
Variations since implementation of HCCS	-	-8.465	-14.770	**-23.235**	**-23.235** [§]
Exceptional Claims Scheme[Δ]	-	-	-	**-**	**-**
Medical Indemnity Subsidy Scheme, including: • Medical indemnity insurance framework – rural obstetricians; and • Medical indemnity subsidy scheme – extension.	29.594	17.701	18.376	**65.671**	**9.771**
Premium Support Scheme, including: • Medical indemnity – additional assistance for rural procedural general practitioners. (Also appears in the 2004-05 Portfolio Budget Statements.)*	-	22.096	32.360	**54.456**	**25.671**

Medical indemnity insurance – Incurred-but-not-reported scheme (estimated claims)[¥]	-	82.000	38.600	**120.600**	**120.600** [§]
Medical indemnity – incurred-but-not-reported indemnity scheme levy (18 month moratorium and exemptions – revenue foregone)	-	42.479	24.878	**67.357**	**67.357** [§]
Medical indemnity insurance – Incurred-but-not-reported scheme (levy revenue)	-	*-11.400*	*-31.501*	***-42.901***	
Medical indemnity – changes to United Medical Protection (UMP) liability contributions. (Also appears in 2004-05 Portfolio Budget Statements.)	-	*-0.697*	*6.651*	***5.954***	
Total revenue under the IBNR and UMP support payment arrangements as at 30 June 2005	**-**	**-12.097**	**-24.850**	**-36.947**	**-34.747**
Expense under the Run-off Cover Scheme[‡]	**-**	**-**	22.800	**22.800**	**22.800** [§]
Revenue under the Run-off Cover Scheme	**-**	**-**	-16.830	**-16.830**	**-14.138**
Medical indemnity policy review/2005 policy review working party[△]	-	-	-	**-**	**-**
Total	**48.649**	**182.179**	**131.834**	**362.662**	**282.869**

[§] Actual expense includes liabilities for claims as they are notified, as is consistent with the Australian Government's accrual accounting method. For this reason, actual expense equals estimated claims. Claims expenses under medical indemnity schemes are based on advice from the Australian Government Actuary.

* Costs for this measure absorbed by the Department of Health and Ageing.

[†] The financial statements in the Department's 2004-05 Annual Report show a liability of $180 million for the High Cost Claims Scheme. This liability was estimated for the purposes of the Department's financial statements and is larger than what has been estimated in the relevant Budget papers. The estimate for the Annual Report accounts for possible future claims as well as a movement of liabilities from the Incurred But Not Reported (IBNR) Liability Scheme where claims may be paid in part under the High Cost Claims Scheme. Alternatively, the relevant Budget papers reflect claims that come into the High Cost Claims Scheme on a year to year claims notified basis.

[¥] The financial statements in the Department's 2004-05 Annual Report show a liability of $245 million for the Incurred But Not Reported Liability Scheme after accounting for the operation of the High Cost Claims Scheme and the Run-Off Cover Scheme.

[‡] The financial statements in the Department's 2004-05 Annual Report show a liability of $41 million for the Run-Off Cover Scheme. This liability figure includes a movement of liabilities from the Incurred But Not Reported Liability Scheme where claims may be paid under the Run-Off Cover Scheme.

[△] There is no estimate of administered expenditure for this measure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-306

OUTCOME 10: Acute Care

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

What is the estimated net effect of all measures following, and including, the introduction of measures flowing from the Graham Rogers report into the competitive neutrality effects of the Government's assistance to UMP?

Answer:

The Competitive Neutrality measures only affect revenue measures under the incurred but not reported (IBNR)/United Medical Protection Support Payments (UMPSP) schemes. The revenue from the competitive advantage payment applied to United Medical Protection (UMP) goes into consolidated revenue.

The net effect of the Competitive Neutrality measures is detailed in the table below:

	2003-04 $m	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Current 4 Year Forward Estimates Total $m
Revenue changes due to Competitive Neutrality measures							
Estimated revenue under IBNR/UMPSP measures	-12.097	-24.850	-26.700	-24.700	-21.500	-19.200	**92.100**
Estimated revenue under IBNR/UMPSP measures after Competitive Neutrality changes	-12.097	-24.850	-13.800	-12.800	0.000	0.000	**-26.600**
Total revenue foregone due to Competitive Neutrality changes			12.900	11.900	21.500	19.200	**65.500**

Increase in revenue due to Competitive Advantage Payments by United Medical Protection			-9.338	-9.068	-8.710	-8.324	**-35.440**
Total Net Effect of Competitive Neutrality measures	-	-	**3.562**	**2.832**	**12.790**	**10.876**	**30.060**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-349

OUTCOME 10: Acute Care

Topic: MEDICAL INDEMNITY

Hansard Page: CA 16

Senator Carol Brown asked:

Can the Department provide a line by line breakdown of all medical indemnity measures since November 2001? For each of these measures please provide the estimated cost and the corresponding actual cost.

Answer:

A breakdown of all medical indemnity measures since November 2001 is detailed in the table below:

Budget context	Title of measure
2002-03 additional estimates	Medical indemnity insurance – assistance package
	Medical indemnity insurance – Incurred-but-not-reported levy
	Medical indemnity insurance – Incurred-but-not-reported scheme
	United Medical Protection (UMP)/Australasian Medical Insurance Ltd (AMIL) guarantee
2003-04 budget	Medical indemnity insurance framework – rural obstetricians
2003-04 additional estimates	Medical indemnity – extension of high cost claims scheme
	Medical indemnity – lowering high cost claims scheme (HCCS) threshold to $300,000[#]
	Medical indemnity – additional assistance for rural procedural GPs[#]
	Medical indemnity – premium support scheme[#]
	Medical indemnity subsidy scheme – extension
	Medical indemnity – incurred-but-not-reported indemnity scheme levy
	Medical indemnity – exceptional claims scheme
	Medical indemnity – changes to United Medical Protection (UMP) liability contributions[#]
	Medical indemnity – 2005 policy review working party[#]
	Medical indemnity policy review
	Medical indemnity – run-off reinsurance vehicle (RRV)[#]

2004-05 budget[#]	Medical indemnity – 2005 policy review working party
	Medical indemnity – additional assistance for rural procedural GPs
	Medical indemnity – changes to United Medical Protection (UMP) liability contributions
	Medical indemnity – high cost claims scheme threshold reduction
	Medical indemnity – premium support scheme
	Medical indemnity – run-off reinsurance vehicle
2004-05 additional estimates	Medical indemnity – run-off cover scheme

[#]These measures correspond to measures published in the department's 2003-04 Portfolio Additional Estimates Statements. They were republished in the 2004-05 budget because their costs were not reflected in the 2003-04 Mid-Year Economic and Fiscal Outlook (MYEFO).

Liabilities under the medical indemnity schemes are estimated on a per financial year basis. As such, the total administered cost for the medical indemnity package can only be provided as at 30 June 2005 rather than at the time of the question. Total administered costs are set out below:

	2002-03 $m	2003-04 $m	2004-05 $m	Total estimated costs to 30 June 2005 $m	Total actual costs to 30 June 2005 $m
Competitive Neutrality arrangements – increased revenue	-	-	-	**-**	**-**
High Cost Claims Scheme (HCCS)[†]	19.055	19.055	19.055	**57.165**	**57.165** [§]
Extension of High Cost Claims Scheme	-	14.210	21.315	**35.525**	**35.525** [§]
Lowering high cost claims scheme (HCCS) threshold to $300,000.	-	5.200	10.900	**16.100**	**16.100** [§]
Variations since implementation of HCCS	-	-8.465	-14.770	**-23.235**	**-23.235** [§]
Exceptional Claims Scheme[Δ]	-	-	-	**-**	**-**
Medical Indemnity Subsidy Scheme, including: • Medical indemnity insurance framework – rural obstetricians; and • Medical indemnity subsidy scheme – extension.	29.594	17.701	18.376	**65.671**	**9.771**
Premium Support Scheme, including: • Medical indemnity – additional assistance for rural procedural general practitioners. (Also appears in the 2004-05 Portfolio Budget Statements.)*	-	22.096	32.360	**54.456**	**25.671**

Medical indemnity insurance – Incurred-but-not-reported scheme (estimated claims)[¥]	-	82.000	38.600	**120.600**	**120.600** [§]
Medical indemnity – incurred-but-not-reported indemnity scheme levy (18 month moratorium and exemptions – revenue foregone)	-	42.479	24.878	**67.357**	**67.357** [§]
Medical indemnity insurance – Incurred-but-not-reported scheme (levy revenue)	-	*-11.400*	*-31.501*	***-42.901***	
Medical indemnity – changes to United Medical Protection (UMP) liability contributions. (Also appears in 2004-05 Portfolio Budget Statements.)	-	*-0.697*	*6.651*	***5.954***	
Total revenue under the IBNR and UMP support payment arrangements as at 30 June 2005	**-**	**-12.097**	**-24.850**	**-36.947**	**-34.747**
Expense under the Run-off Cover Scheme[‡]	**-**	**-**	22.800	**22.800**	**22.800** [§]
Revenue under the Run-off Cover Scheme	**-**	**-**	-16.830	**-16.830**	**-14.138**
Medical indemnity policy review/2005 policy review working party[△]	-	-	-	**-**	**-**
Total	**48.649**	**182.179**	**131.834**	**362.662**	**282.869**

[§] Actual expense includes liabilities for claims as they are notified, as is consistent with the Australian Government's accrual accounting method. For this reason, actual expense equals estimated claims. Claims expenses under medical indemnity schemes are based on advice from the Australian Government Actuary.

* Costs for this measure absorbed by the Department of Health and Ageing.

[†] The financial statements in the Department's 2004-05 Annual Report show a liability of $180 million for the High Cost Claims Scheme. This liability was estimated for the purposes of the Department's financial statements and is larger than what has been estimated in the relevant Budget papers. The estimate for the Annual Report accounts for possible future claims as well as a movement of liabilities from the Incurred But Not Reported (IBNR) Liability Scheme where claims may be paid in part under the High Cost Claims Scheme. Alternatively, the relevant Budget papers reflect claims that come into the High Cost Claims Scheme on a year to year claims notified basis.

[¥] The financial statements in the Department's 2004-05 Annual Report show a liability of $245 million for the Incurred But Not Reported Liability Scheme after accounting for the operation of the High Cost Claims Scheme and the Run-Off Cover Scheme.

[‡] The financial statements in the Department's 2004-05 Annual Report show a liability of $41 million for the Run-Off Cover Scheme. This liability figure includes a movement of liabilities from the Incurred But Not Reported Liability Scheme where claims may be paid under the Run-Off Cover Scheme.

[△] There is no estimate of administered expenditure for this measure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-350

OUTCOME 10: Acute Care

Topic: MEDICAL INDEMNITY

Hansard Page: CA 16

Senator Carol Brown asked:

What has been the total cost to the Commonwealth of the assistance given to the medical indemnity sector and doctors since November 2001?

Answer:

The total cost of assistance given to medical indemnity industry and doctors is $282.869 million as at 30 June 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-351

OUTCOME 10: Acute Care

Topic: MEDICAL INDEMNITY

Hansard Page: CA 16

Senator Carol Brown asked:

What is the estimated net effect of all measures following, and including, the introduction of measures flowing from the Graham Rogers report into the competitive neutrality effects of the Government's assistance to UMP?

Answer:

The Competitive Neutrality measures only affect revenue measures under the incurred but not reported (IBNR)/United Medical Protection Support Payments (UMPSP) schemes. The revenue from the competitive advantage payment applied to United Medical Protection (UMP) goes into consolidated revenue.

The net effect of the Competitive Neutrality measures is detailed in the table below:

	2003-04 $m	2004-05 $m	2005-06 $m	2006-07 $m	2007-08 $m	2008-09 $m	Current 4 Year Forward Estimates Total $m
Revenue changes due to Competitive Neutrality measures							
Estimated revenue under IBNR/UMPSP measures	-12.097	-24.850	-26.700	-24.700	-21.500	-19.200	**92.100**
Estimated revenue under IBNR/UMPSP measures after Competitive Neutrality changes	-12.097	-24.850	-13.800	-12.800	0.000	0.000	**-26.600**
Total revenue foregone due to Competitive Neutrality changes			12.900	11.900	21.500	19.200	**65.500**

Increase in revenue due to Competitive Advantage Payments by United Medical Protection			-9.338	-9.068	-8.710	-8.324	**-35.440**
Total Net Effect of Competitive Neutrality measures	-	-	**3.562**	**2.832**	**12.790**	**10.876**	**30.060**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-305

OUTCOME 10: Acute Care

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

What has been the total cost to the Commonwealth of the assistance given to the medical indemnity sector and doctors since November 2001?

Answer:

The total cost of assistance given to medical indemnity industry and doctors is $282.869 million as at 30 June 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-200

OUTCOME 10: Acute Care

Topic: PATHOLOGY SERVICES

Written Question on Notice

Senator McLucas asked:

a) When will the Minister respond to the recommendations of the Fox Phillips [sic] report?

b) Does the Department agree that action on the recommendations in the report could save at least $50 million from inappropriate practices?

Answer:

a) It is expected that the Minister will release the Government response to the Phillips Fox *Review of Enforcement and Offence Provisions of the Health Insurance Act 1973 as they Relate to the Provision of Pathology Services Under Medicare* within the next few weeks.

b) The department is unable to quantify the cost of alleged inappropriate practices in the Pathology sector.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-201

OUTCOME 10: Acute Care

Topic: PATHOLOGY SERVICES

Written Question on Notice

Senator McLucas asked:

a) Is the Department aware of inappropriate payments in relation to:
   i. Excessive rental payments made for collection centres
   ii. Payments made for access to medical practitioner pathology requesting pattern statistical survey data by third parties
   iii. Provision of a payment to the referrer, based on volume of referrals
   iv. Provision of nursing staff, IT equipment, or non-pathology-related consumables to a pathology referrer
   v. Payment of an "option to purchase the goodwill of a practice" to a medical referrer

b) What has the Department done to address these inappropriate practices? When will the Department move to address these practices?

Answer:

a) The department is aware of allegations of such inappropriate practices - most recently from claims made during a *Review of Enforcement and Offence Provisions of the Health Insurance Act 1973 as they Relate to the Provision of Pathology Services Under Medicare*. A Report of that Review, conducted for the department by Phillips Fox, was released by the Minister on 1 September 2005.

b) Investigations into specific allegations of inappropriate practices in the pathology section are conducted by Medicare Australia.

   However, the Review has identified the need for changes to legislation to allow for more effective enforcement of measures to prevent these inappropriate practices.

   The department commissioned the Review to look at the existing pathology enforcement and offence provisions and to recommend changes to clarify and strengthen the regulatory framework.

   It is expected that a Bill to amend the pathology enforcement and offence provisions in the *Health Insurance Act 1973*, reflecting the broad intent of the Review, will be introduced in Parliament in 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-202

OUTCOME 10: Acute Care

Topic: PATHOLOGY SERVICES

Written Question on Notice

Senator McLucas asked:

Is there any evidence to suggest that the Private sector Pathology Episode Initiation (PEI) fee is the source of funds for these inappropriate practices?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-203

OUTCOME 10: Acute Care

Topic: PATHOLOGY SERVICES

Written Question on Notice

Senator McLucas asked:

Is there any move to provide a PEI fee to public pathology practices?

Answer:

The Government's intention to provide access to the Patient Episode Initiation (PEI) Medicare benefits item for public pathology practices is detailed in the Pathology Quality and Outlays Memorandum of Understanding 2004-2009 (Pathology MoU).

The Pathology MoU anticipates that Approved Pathology Providers, working in public pathology practices and exercising their rights to private practice, will be able to begin claiming PEI fees from 1 May 2007.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-308

OUTCOME 10: Acute Care

Topic: WEIPA HOSPITAL

Written Question on Notice

Senator McLucas asked:

a) In Supplementary Estimates on November 2 I raised the issue of an election promise of $5 million for Weipa Hospital. Can the department explain the processes by which $5 million could be provided for the new greenfields hospital?
b) What departmental allocation could provide such funds?
c) How could such funds be applied to Weipa Hospital?

Answer:

(a), (b) and (c)

The Queensland Government will receive $8 billion over 5 years from the Australian Government for public hospital funding under the 2003-2008 Australian Health Care Agreements. The Queensland Government could direct some of this funding to redeveloping the Weipa Hospital if this was seen as a priority.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-06, 2 November 2005

Question: E05-309

OUTCOME 10: Acute Care

Topic: WEIPA HOSPITAL

Written Question on Notice

Senator McLucas asked:

Have any departmental funds been earmarked for Weipa Hospital?

Answer:

There is no funding earmarked for Weipa Hospital. However, Queensland will receive up to $8 billion in Australian Government funding under the 2003-08 Australian Health Care Agreement.

Capital funding is not specifically allocated in the Agreement but the Queensland Government is free to prioritise how the funding will be allocated, including making the decision to provide capital funding for the Weipa project.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-06, 2 November 2005

Question: E05-310

OUTCOME 10: Acute Care

Topic: WEIPA HOSPITAL

Written Question on Notice

Senator McLucas asked:

As at November 2 2005, had any request been made for $5 million in departmental funds to be allocated to Weipa Hospital?

Answer:

Not to the Department's knowledge.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, November 2005

Question: E05-004

OUTCOME 11: Health and Medical Research

Topic: AUSTRALIAN STEM CELL CENTRE

Written Question on Notice

Senator Fielding asked:

What information can the Council provide on any projects they are providing funding for that are being carried out by the Australian Stem Cell Centre? Please provide a report on the progress of each project.

Answer:

The National Health and Medical Research Council is not currently providing any funding for the Australian Stem Cell Centre.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-018

OUTCOME 11 – Health and Medical Research

Topic: LEGISLATION REVIEW COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

a) According to the Lockhart Legislative Review Committee website, the Committee will review the legislation and report back to COAG by December 19. Is the Committee on schedule to report back by that date?
b) What process occurs after the Committee reports back?
c) In what time frame will the Government release a response to the report?
d) In what time frame will potential amendments be made to the legislation?

Answer:

a) The Committee will report before 19 December 2005.

b), (c) and (d) The Australian and State and Territory Governments will consider the reports of the reviews in 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-019

OUTCOME 11 – Health and Medical Research

Topic: LEGISLATION REVIEW COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

a) Given the Review was announced on 17 June 2005, hearings did not begin until September 1 and the Committee must report back by December 19, has the Committee had sufficient time to conduct this review?
b) What is the likelihood of the Lockhart Legislative Review Committee's recommendations being implemented?
c) What is the time frame for recommendations to be acted upon?

Answer:

a) The Committee has had sufficient time to conduct the reviews.
b) and (c) The Australian and State and Territory Governments will consider the reports of the reviews in 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-020

OUTCOME 11 – Health and Medical Research

Topic: LEGISLATION REVIEW COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

There is a concern in the research community that leaving the legislation unchanged or further restricting access to embryonic stem cells for research purposes will result in an exodus of scientists from Australia and will hinder recruitment of scientists from overseas. (http://www.abc.net.au/science/news/stories/s1453523.htm). What steps is the Government taking to ensure this does not happen?

Answer:

The Legislation Review Committee, chaired by the Hon John Lockhart AO QC, completed the reviews of the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002* in December 2005. The reports are available on the Legislation Review Committee website at www.lockhartreview.com.au

The Australian Government will examine the findings of the reviews over coming months.

The Department cannot comment on decisions that may be made in that context or hypothetical propositions that may be canvassed in the media.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-021

OUTCOME 11 – Health and Medical Research

Topic: LEGISLATION REVIEW COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

Australian ethicist, Professor Julian Savelescu has said "if Australia does not lift the ban on therapeutic cloning, it will be obliged on the same ethical grounds to ban cures that flow from the technique carried out in other countries." (The Age 30/09/05). If the ban on therapeutic cloning is not lifted, will the Government move to ban cures developed from this technique in other countries?

Answer:

Please refer to answer to Question: E05-020.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-009

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

Please provide a list of the other uses for human embryos, approved by the Licensing Committee and how many embryos have been approved for use for each particular item in the list.

Answer:

Details of all licences issued by the National Health and Medical Research Council Licensing Committee, including the authorised uses and the number of embryos authorised to be used, is provided on the NHMRC website at www.nhmrc.gov.au/embryos/monitor/database/index.htm.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-005

OUTCOME 11 – Health and Medical Research

Topic: LICENSING COMMITTEE

Written question on notice

Senator Fielding asked:

In the NHMRC submission to the Lockhart Legislation Review Committee, the Australian Health Ethics Committee proposed that "… the LRC considering amending the legislation to permit the initial ethical review of licence applications to be conducted by a central ethics committee …". What does 'central ethics committee' mean and how would such a system work in practice? Does it mean ad hoc groups formed to consider applications that Human Research Ethics Committees are too busy to consider? Isn't the criticism of Human Research Ethics Committees that, as institutional-based committees, they are already too close to the people and the institution doing the research to make impartial decisions? Isn't the solution to improve the HREC system, rather than bypass it?

Answer:

The proposal from the Australian Health Ethics Committee in the submission to the Legislation Review Committee proposed the establishment of a single, formally established 'centralised' ethics committee to undertake ethical review only of proposals for research involving the use of excess Assisted Reproductive Technology (ART) embryos, as required by the *Research Involving Human Embryos Act 2002*. If established, any such committee would be constituted and operate in accordance with the National Statement on Ethical Conduct in Research Involving Humans (1999).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-006

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

a) How many human embryos have, under licenses issued by the Licensing Committee, been used to create embryonic stem cells?
b) What percentage is the number of embryos used to create embryonic stem cells of all embryos used under license?

Answer:

a) The National Health and Medical Research Council (NHMRC) Licensing Committee has issued four licences for the derivation of human embryonic stem cell lines. By the end of the July – September 2005 quarter, 85 excess Assisted Reproductive Technology (ART) embryos had been used under these licences.
b) By the end of the July – September 2005 quarter, a total of 120 excess ART embryos had been used under licences issued by the NHMRC Licensing Committee, with 85 (71%) of these having been used for the derivation of human embryonic stem cell lines.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-007

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

How many human embryos have, under licences issued by the Licensing Committee, been used in work to find therapies or cures? What percentage do they form of all embryos licensed for use by the Licensing Committee?

Answer:

National Health and Medial Research Council (NHMRC) Licensing Committee has issued four licences authorising the derivation of new embryonic stem cell lines for use in medical research and four authorising the use of excess Assisted Reproductive Technology (ART) embryos in medical research directed at improving the success rate of assisted reproductive technology. These licences authorise the use of up to 1560 excess ART embryos, or 90 % of all excess ART embryos authorised to be used under NHMRC licences. By the end of the July – September 2005 quarter, 120 excess ART embryos had been used under these eight licences. This represents 100% of the excess ART embryos used to date under licences issued by the NHMRC Licensing Committee. Full details of all licences issued by the Licensing Committee are provided on the NHMRC website (www.nhmrc.gov.au).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-008

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

How many human embryos have, under licenses issued by the Licensing Committee, been used to produce embryonic stem cells for transplants? Please provide details.

Answer:

The National Health and Medical Research Council (NHMRC) Licensing Committee has issued four licences for the derivation of human embryonic stem cell lines for use in medical research, of which use in transplants is one possible outcome. By the end of the July – September 2005 quarter, 85 excess Assisted Reproductive Technology (ART) embryos had been used under these four licences.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-011

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

The Licensing Committee has provided minutes of its meetings to the Community Affairs Committee. Please provide copies of minutes for any further meetings.

Answer:

The minutes of the 31 August – 1 September 2005 meeting of the NHMRC Licensing Committee are attached.

NHMRC LICENSING COMMITTEE

Minutes of the Meeting of 31st August – 1st September 2005
Ballroom 1, Stamford Grand Glenelg, Adelaide.

9.00am to 6.00pm Wednesday 31 August 2005

8.30am to 12.00pm Thursday 1 September 2005

ATTENDANCE

Members:	**Secretariat:**
Professor Jock Findlay (Chairperson)	Dr Clive Morris
Professor Don Chalmers (Deputy Chair)	Dr Greg Ash
Professor Peter Illingworth	Mr Phillip Hoskin
Dr Graham Kay	Dr Alison Mackerras
Dr Helen Szoke	Mr Martin Boling
Dr Julia Nicholls	Dr Harry Rothenfluh
A/Professor Christopher Newell	Ms Celia Jobson (Secretary)
Professor Bryan Campbell	Dr Mike Gear
Legal Services Branch:	
Mr Neil Dwyer	

Day One

9am – 11.15am - Out of Session activity

Licensing Committee members attended a tour of an IVF Clinic in Adelaide hosted by the Clinical Directors and staff. Members saw first hand how an IVF clinic can be managed and operated. This provided insight into the sorts of experience clients may undergo and how the scientific elements may be handled, including the logistics of how an IVF clinic may be organised for undertaking specialised medical and scientific procedures. Following the tour, members engaged in informal conversations over morning tea with the Clinical Directors and staff of the Clinic.

Outcome: Members agreed the opportunity to visit an IVF Clinic was a valuable experience.

Action Arising: Secretariat will draft a letter of thanks and appreciation from the Chair of the Committee to the IVF Clinic visited.

Item 1: Opening

The meeting commenced at 1pm on Wednesday 31st August 2005.

Item 1.1: Apologies

There were no apologies for the meeting.

Item 1.2: Confidentiality and Conflict of Interest

Members were reminded of their obligations in respect of confidentiality and conflict of interest declarations.

A possible conflict of interest was declared by Professor Illingworth for licence applications and variations. This was dealt with in accordance with NHMRC procedures.

Decision: Members agreed that under Section 16(3)(c) of the *Research Involving Human Embryos Act 2002* Professor Illingworth does have a conflict of interest that would preclude his future involvement with the Committee**.** In terms of dealing with the Conflict of Interest at this meeting, members decided that Professor Illingworth should not take part in any discussion around Items 6 and 7 and parts of Item 10. The Chair and members thanked Professor Illingworth for his valuable input to the Committee and noted that his contributions and expertise will be missed.

Action Arising: Professor Illingworth to submit his resignation to the Minister.

Item 1.3: Confirmation of Agenda

The timing of agenda items was confirmed. Members were invited to identify any non-starred item that required discussion.

Item 1.4: Chairman's Report

Members were informed that since the last meeting of the Committee, the Chair had participated in:

- Overseas working commitments during the month of June 2005;
- A monitoring inspection of Licence Holder premises as an observer to the activities undertaken by NHMRC Inspectors;
- NHMRC Management Committee meeting of 21 July 2005; and
- NHMRC Licensing Committee Secretariat meeting on 18 August 2005.

The Licensing Committee Chair's Report to Council for its meeting of 8-9 September 2005 to be held in Canberra was tabled.

Members noted that the Chair will be participating in the Endocrine Society of Australia (EAS) and the Society for Reproductive Biology (SRB) Annual Scientific Meeting at the Perth Convention Centre, WA from 4 – 7 September 2005. A member

from the Licensing Committee Secretariat will also be attending. Members of the Licensing Committee Secretariat will also be providing representation for the Committee and the NHMRC at the Fertility Society of Australia (FSA) Annual Meeting, Christchurch NZ from 4 – 7 September 2005.

Members also noted the Chair's proposed meeting with the Minister following the Council meeting in Canberra 9 September 2005, to provide a report on the work of the Committee to date.

Item 1.5: Out of Session Activities

Members noted Out of Session decisions made by the Committee since the 1 June 2005 meeting, as presented in the meeting papers including:

- One administrative variation to Licence 309708 to remove personnel from the list of Authorised Persons. The Committee endorsed the proposed Licence variation and it was implemented on 12 July 2005.
- Several teleconferences were held during August 2005 by Professor Findlay, Professor Chalmers and Secretariat to progress the Licensing Committee's contribution to the NHMRC's submission to the Legislative Review Committee.

Item 1.6: Committee Membership

Members noted that the Minister is still working to appoint a replacement for Dr Megan Best who resigned in 2004. The Committee agreed that the work of the Committee was impeded by the lack of a person with expertise in research ethics.

Outcome: Members noted that the Secretariat will continue to work with the Minister to facilitate the appointment.

Item 2: Minutes and Action Arising from Previous Meeting

The draft minutes of the 1 June 2005 meeting were endorsed by members. The table detailing progress on Action Arising from the meeting of 1 June 2005 was noted.

Item 3: NHMRC Activities

Secretariat briefed the Committee on the known future governance arrangements of the NHMRC. Members noted the end of triennium was approaching and committee membership would be addressed in the near future.

Members noted Secretariat staff movements and extended their appreciation to two Secretariat members leaving the Secretariat team, and thanked them for their valued input during their time with the team.

Item 3.1: Council Activities

Members noted the report provided by the Council Secretariat.

Item 3.2: Report by AHEC Representative

Professor Campbell provided a verbal report to inform members about matters considered by AHEC since the 1 June 2005 meeting of the Licensing Committee.

Outcome: Members noted that:

- a sub-committee of AHEC had been established to review the use of foetal tissue;
- a working party had been established under the auspices of the Australian Health Ministers' Advisory Council (AHMAC) by the NSW Health Department to review the donations of live liver transplants. AHEC is represented on this working party;
- a sub-committee of AHEC had been established to review post coma unresponsiveness; and
- AHEC had expressed strong concerns regarding research governance and the role of HREC's in that context in its recent meeting.

Item 3.3: Interaction with GTRAP

Members were provided with a written update of issues being considered by GTRAP.

Item 3.4: Secretariat Activities

Members noted the summary report on Centre for Compliance and Evaluation administrative activities and staff movements.

Item 3.5: Report on European Society of Human Reproduction and Embryology

The Secretariat provided members with a written report of the meeting, held in Copenhagen, Denmark on 19 - 22 June 2005.

Item 4: Budget

The Secretariat updated members on the Licensing Committee Projects in progress.

Item 4.1: Licensing Committee Projects

Members noted that Departmental procurement processes had changed and impacted on work programs.

Action Arising: Secretariat to progress agreed projects and report to the 23 - 24 November 2005 meeting. Members noted that the Commercial-Off-The-Shelf (COTS) database should be in place by December 2005.

Item 5: Biannual Report to Parliament

Members were updated on the progress of the drafting of the 6th Biannual Report to Parliament for the reporting period of 1 April 2005 – 30 September 2005.

Action Arising: Secretariat to draft the report and circulate to the Committee for input in October 2005.

Item 6: Licence Considerations

Possible conflicts of interest were declared and dealt with in accordance with NHMRC procedures.

Item 6.1: Applications

Members noted that since the 1 June 2005 meeting of the NHMRC Licensing Committee there have been no new Licence Applications submitted and no Licence Applications were currently undergoing assessment.

Item 6.2: Variations

A possible conflict of interest was declared by Professor Campbell and left the room for discussion of Agenda Items 6.2.2, 6.2.3, and 6.2.4. This was dealt with in accordance with NHMRC procedures.

Item 6.2.1: Summary of all Variations

Secretariat tabled a summary spreadsheet of all variations to Licences, both ongoing and completed. Members noted the summary of licence variations.

Item 6.2.2: Application to Vary Licence 309703

Members discussed the application to vary Licence 309703 to add an additional facility to the list of authorised sites.

Decision:
Committee Members varied conditions 9201 and 9202 of Licence 309703 under s25 of the Research *Involving Human Embryos Act 2002* by adding the additional facility to the list of authorised sites, on the basis that the variations were consistent with the s.21(4) and furthered the goals of the project.

Item 6.2.2A: Discussion on Licence Variation versus New Licence Application

The current licence variation applications prompted questions from the Committee of what constitutes a licence variation and what requirement existed for a new licence. Issues raised in discussion included a continuation of previous meeting discussion points. The discussion included:

- whether new or changed objectives or activities may result from the variation
- significant changes that were not of an administrative nature

- a change in procedures requiring ethical consideration
- variations where a new organisation or person/s become involved who may benefit substantially from the licensed activity
- the variation may require a change in the number of excess ART embryos to be use
- any other change that would lead to an alteration of the consent process, noting that the provisions of s25 (4) applies. For example, if the consent process is changed and/or requires re-consent by responsible persons this is an indicator that the activity has changed significantly, and
- addressing any changes in perceptions of the objectives of the licence.

Outcome: Members agreed that where a request to vary a Licence could potentially result in a change in consent processes, including any related perceptions, this would constitute the necessity for an application for a new licence rather than remain as a licence variation. Members agreed that further consideration needed to be given to the issue of review of progress with a licence when a request for a variation is sought.

Action Arising: Secretariat to consider Section 25 (4) of the *Research Involving Human Embryos Act 2002* to compile a draft policy for discussion by members at the next Licensing Committee meeting.

Item 6.2.3: Application to Vary Licences 309701, 309702A and 309702B

Members discussed the application to vary Licences 309701, 309702A and 309702B to add an additional facility to the list of authorised sites. Members agreed that additional information needed to be obtained and resolved to raise the following issues with the Licence Holder:

1. comment on the perception that the goals / objectives of the projects have changed focus on the other licences to the production of embryonic stem cells to the detriment of the objectives
2. justify why the number of excess ART embryos authorised to be used to produce stem cells should not be reduced since the Licence Holder has requested changes to their consent documents because they have "experience with high stem cell derivation rates obtained with collaborating partner IVF programs outside Australia"
3. provide details of record keeping for monitoring purposes (including recording exactly where all documents will be at specific times)
4. resolution that further ethical approval is not required. Request clarification of the issue with respect to the other licences
5. clarify the relationship between the four licences

Action Arising: As several issues remain unresolved the Committee agreed to progress this application out-of-session. Secretariat and working group to draft and send a letter to the Licence Holder requesting answers to the five questions identified during discussion.

Working group and Secretariat representative to visit Licence Holder, if necessary.

Item 6.2.4: Application to Vary Licence 309703

Members discussed the application to vary the consent documents of Licence 309703. The stage 1 consent documents were endorsed by the Committee subject to correcting typographical errors. Members noted that the Stage 2 consent documents relate to activities outside the scope of the *Research Involving Human Embryos Act 2002,* and that these documents should not contain references to the *Research Involving Human Embryos Act 2002.* Members noted that the Licence Holder's letters required updating.

Decision: The Committee endorsed the Stage 1 consent documents.

Action Arising: Secretariat to contact the Licence Holder to request amendments to the Stage 2 consent documents and the letters reporting the links between their four licences. Secretariat to report back to the Licensing Committee next meeting.

Item 6.3: Consent – Advice Received to Date

Members noted the proper consent notifications received from Licence Holders to date.

Item 6.3.1: Consent Checklist

Members noted the Action Arising taken to distribute the revised consent checklist.

Action Arising: Secretariat to circulate the revised checklist to Committee members for viewing.

Item 7: Compliance and Assessment

Possible conflicts of interest were declared and dealt with in accordance with NHMRC procedures.

Item 7.1: Update on Compliance Communication Arrangements with States and Territories

Members noted progress in developing compliance and communication arrangements with the States and Territories.

Item 7.2: Report on Records Audit Inspections

Members noted that no Records Audit Inspections had been conducted since the last Licensing Committee meeting of 1 June 2005. Records Audit Inspections are carried out shortly after new licences are issued.

Item 7.3: Report on Monitoring Inspections

Members noted the monitoring inspection activities undertaken since the last Licensing Committee Meeting of 1 June 2005. Full copies of the reports were made available to the Committee.

Decision: The Committee was satisfied with the outcomes and endorsed the Monitoring Inspection Reports.

Action Arising: A summary of these monitoring Inspections to be included in the next Licensing Committee Report to Parliament.

Item 7.4: Licence 309708

Members noted the recent developments in relation to the authorised sites under Licence 309708 and subsequent action undertaken by NHMRC Inspectors.

Outcome: The Committee noted the information provided.

Item 7.5: Report on a visit to the Human Fertilisation & Embryology Authority (HFEA) June 2005

Members noted the report on the visit to the HFEA by the Chairperson of the Licensing Committee and an NHMRC Inspector during June 2005. A full report was made available to Committee members.

Action Arising: The Committee agreed that a video conference meeting between the HFEA and NHMRC would be valuable for the exchange of information. The Secretariat to organise the first of these before the next Licensing Committee meeting.

Item 7.6: Report on investigation into breach of Licence 309707

Possible conflicts of interest were declared and dealt with in accordance with NHMRC procedures. Professor Don Chalmers chaired the meeting for this Agenda Item. A quorum was present for the discussion and decision making process.

The NHMRC Licensing Committee issued Licence 309707 on 21 December 2004. This licence authorises the Licence Holder to use of up to 200 excess ART embryos to derive twenty human embryonic stem cell lines with enhanced stability, greater capacity to differentiate and freedom from contamination by animal products.

On 9 August 2005, the NHMRC Inspectors identified a breach of a condition of Licence 309707. The Licence Holder had failed to notify the NHMRC that proper consent had been obtained prior to using excess ART embryos in research authorised by the licence.

On 9 to 10 August 2005, the NHMRC Chief Inspector conducted an initial assessment of the issue, contacted the Licence Holder and sought legal advice from the Department of Health and Ageing Legal Services Branch.

On Monday 15 August 2005, NHMRC Inspectors conducted a short-notice inspection of the Licence Holder. The intention of the inspection was to establish the facts associated with the suspected breach of the legislation and to ensure that the non-compliance would not be repeated. NHMRC Inspectors confirmed that proper consent had been obtained in relation to each excess ART embryo prior to its use and that the failure to report was an administrative oversight.

On 18 August 2005, a brief of evidence was provided to the Commonwealth Director of Public Prosecutions (CDPP) for advice. The NHMRC is awaiting advice from the CDPP in relation to this matter.

The NHMRC Licensing Committee discussed appropriate administrative actions, including varying the licence to add a new special condition in order to further clarify the licence holder's responsibilities in relation to reporting to the Committee.

Decision: The NHMRC Licensing Committee noted:

- and endorsed the actions undertaken by the NHMRC Inspectors, including the short notice inspection and referral of the matter to the Commonwealth Director of Public Prosecutions;
- that a breach of s24 had occurred;
- that the Licence Holder admitted fault;
- that the DPP has not yet formally responded to the referral;
- the quick and cooperative response of the Licence Holder to the issue, their acknowledgement of the seriousness of situation, and their collaborative approach to dealing with the issue; and
- the communications from the Licence Holder's Deputy Vice-Chancellor (Research) requesting receipt of further correspondence in relation to this matter.

In relation to this matter the Licensing Committee agreed that:

- Proper consent had been obtained from all responsible persons in compliance with the *Research Involving Human Embryos Act 2002* and the breach consisted only of the failure to notify the NHMRC that proper consent had been obtained. Thus, the Licensing Committee does not consider that the breach was intentional, reckless or likely to be repeated.

- Considering the administrative nature of the breach and the Licence Holder's actions to take responsibility for the breach and quickly put in place corrective actions to ensure it does not happen again, the Licensing Committee determined that it is not appropriate to suspend or revoke the licence under s26 of the *Research Involving Human Embryos Act 2002.*

- The appropriate response to the matter is to vary the special conditions of the licence under s25 of the *Research Involving Human Embryos Act 2002* in order to clarify the Licence Holder's responsibilities in relation to reporting to the Licensing Committee.

- In accordance with s19 of the *Research Involving Human Embryos Act 2002*, a report of the incident and the Committee's determination will be included in the next Biannual Report to Parliament.

- In accordance with s28 of the *Research Involving Human Embryos Act 2002*, the NHMRC will notify the responsible HREC and relevant State government authority when the licence has been varied.

Action Arising: Consequent to the Licensing Committee's determination, the Licensing Committee requested:

- NHMRC Inspectors to inspect the Licence Holder as soon as practicable, to ensure that all systems are in place and working appropriately, and report back to the Committee before the next meeting;
- Secretariat to liaise with the Licence Holder's Deputy Vice-Chancellor (Research) and the Licence Holder's legal representatives seeking clarification of how they want to be included in correspondence in relation to the licence;
- Secretariat to make the variation to the special conditions of the licence for the Committee's consideration;
- Secretariat to provide the Licence Holder with the opportunity to comment on the draft report of the incident that will be published in the next Biannual Report to Parliament;
- Secretariat to inform CDPP of the Committee's decisions and facilitate their response; and
- Secretariat to prepare correspondence to the Licence Holder, informing the Licence Holder of the decisions with the first draft to be circulated before 9 September 2005.

Item 7.7: Report on Short Notice Inspection - Licence 309707

See Agenda item 7.6.

The Chair was invited by the Deputy Chair to rejoin the meeting following the conclusion of this Agenda Item.

Item 8: Biological Definition of Human Embryo

Members discussed the draft document, including peer review comments, from the Working Party and noted the progress of the project.

Outcome: The Committee endorsed the draft document, subject to resolution of some minor issues by the Working Party, and recommended that it submitted to Council.

Item 9: Review of Legislation

Members were provided with information about the establishment of the Legislation Review Committee in June 2005 and the timetable for the development of the NHMRC's submission and its proposed endorsement at the Council meeting on 8-9 September 2005. Members discussed the draft of the Licensing Committee's input to the submission.

Action Arising: Draft to be revised and circulated by Secretariat Out of Session with comments required from members by 7 September 2005. Final document to be submitted to the Legislative Review Committee by end September 2005 as negotiated with Legislative Review Committee Secretariat.

Item 10: Use of Excess ART Embryos created recently in Licensed Activities

Possible conflicts of interest were declared and dealt with in accordance with NHMRC procedures.

Members discussed this issue and legal advice obtained and agreed further consideration is necessary, including consultation with AHEC.

Action Arising: To be discussed further at next meeting. Secretariat to draft responses to relevant correspondence.

Item 11: Communications

Item 11.1: Information Exchange Visits (IEVs)

Members noted the report of the information exchange visit undertaken since the last meeting of 1 June 2005 to the Women's & Children's Hospital Human Research Ethics Committee on 17 August 2005 in Adelaide SA. A full report of the organisations contacted regarding an Information Exchange Visit was provided to members. Members discussed options to explore in order to successfully reach consumers.

Outcome: The Committee noted that a consumer group has requested an Information Exchange Visit to be held in October 2005, and responses were pending from several organisations regarding Information Exchange Visits.

Item 11.2: Information Bulletin

Members noted that the 3rd Information Bulletin will be distributed to consumer groups by Secretariat when available.

Action Arising: Secretariat to finalise printing and distribute to consumer groups and members.

Item 11.3: Targeted Information Sheets

Members noted the status of the targeted information sheets.

Action Arising: Secretariat to progress the publication process of the targeted information sheets, and on members request, include counsellors within IVF Clinics in the distribution list.

Item 11.4: Consumer health update

Members noted the difficulty in engaging with client groups for Information Exchange Visits.

Members agreed that contact with the NHMRC Health Consumer Representatives was one way in which to disseminate information.

Action Arising: Secretariat to draft letter from Chair to Australian consumer group ACCESS regarding improvement in communications with consumer groups and the community.

Secretariat to explore further options including:
- inviting consumer groups to a scheduled Licensing Committee meeting;
- working with State regulatory agencies to disseminate information;
- consulting the NHMRC Information Unit; and
- progressing the Licensing Committee communication strategy.

Item 12: Adoption of 2004 ART Guidelines in Regulations

Members noted that the process to include the 2004 ART Guidelines in the Regulations will be completed shortly.

Item 13: National Application Form

The Committee noted progress on the National Application Form. AHEC Secretariat is working with an Information Technology (IT) consultant on IT components and to progress staged web-based roll-out of the form prior to the end of 2005.

Item 14: Other Business

The Chair gave his thanks and members noted their appreciation of Professor Peter Illingworth for his valuable contribution to the Committee, wishing him well for his future endeavours. Professor Illingworth thanked the Chair and Committee for their feedback.

Item 14.1: Horizon Scanning in conjunction with the HFEA

The Chair reported to members on an exercise undertaken by HFEA whereby a regular horizon scanning forum had been established to communicate emerging technologies and their related progress. The Chair asked members to consider establishing a similar confidential advisory working group for Licensing Committee for the purpose of filtering progressive technologies and related information.

Action Arising: Secretariat to include in proposed video conference (see Item 7.5). Secretariat and communications working group to establish a 'filtering' system for all news and updates circulated in bracketed categories ie. peer reviews, news, media, and community.

Item 14.2: Next Meeting 2005

Members noted the next meeting to be held 23 – 24 November 2005 in Canberra.

Item 14.3: Licensing Committee Meetings for 2006

Members noted the dates for Licensing Committee meetings for 2006 would be proposed at the next meeting in November 2005 due to further information pending regarding governance arrangements of the NHMRC and Council meeting dates for 2006 yet to be determined.

Item 15: Conclusion of Meeting

The meeting concluded at 12:00pm on Thursday 1 September 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-012

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

How many monitoring inspections have been carried out this year? Please provide details of the inspections including copies of the inspection reports.

Answer:

In 2005 the National Health and Medical Research Council (NHMRC) Inspectors conducted the following thirteen inspections:

Licence Holder Name	Licence Number	Inspection Type	Inspection Date
Monash University	309707	Records Audit Inspection	3 February 2005
Monash IVF (Victoria)	309700	Records Audit Inspection	4 April 2005
Monash IVF (Queensland)	309700	Records Audit Inspection	15 April 2005
IVF Australia	309708	Monitoring Inspection	18 April 2005
Melbourne IVF	309704	Monitoring Inspection	7 June 2005
Melbourne IVF	309709	Monitoring Inspection	13 July 2005
Sydney IVF	309701	Monitoring Inspection	11 August 2005
Sydney IVF	309702A	Monitoring Inspection	11 August 2005
Sydney IVF	309702B	Monitoring Inspection	11 August 2005
Sydney IVF	309703	Monitoring Inspection	11 August 2005
Monash University	309707	Short Notice Monitoring Inspection	15 August 2005
Monash University	309707	Monitoring Inspection	4 October 2005
Organisation		**Inspection Type**	**Inspection Date**
Stem Cell Sciences Pty Ltd		Monitoring Inspection (non Licence Holder)	14 July 2005

Summary reports of all of the above inspections are attached. The full inspection reports are not made publicly available since they contain detailed confidential information about the licence holder.

Monitoring Activity	**Records Audit Inspection**
Licence Number	**309707**
Licence Holder	**Monash University**
Monitoring Activity Date	**3 February 2005**
Licence Title	Derivation of embryonic stem cells from the human embryo
Background	• On 21 December 2004, Monash University was issued with Licence 309707.
Inspector Activities Performed	• Inspected and examined relevant documents and records to confirm the integrity of the Monash University record keeping systems relevant to the use of excess Assisted Reproductive Technology (ART) embryos authorised by Licence 309707. • Noted the full cooperation of Monash University which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

Prohibition of Human Cloning Act 2002 Findings	• There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
Research Involving Human Embryos Act 2002 Findings	• There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Records Audit Inspection**
Licence Number	**309700**
Licence Holder	**Monash IVF (Victoria)**
Monitoring Activity Date	**4 April 2005**
Licence Title	Use of excess ART embryos for training in embryo biopsy.
Background	• On 11 March 2005, Monash IVF was issued with Licence 309700.
Inspector Activities Performed	• Inspected and examined relevant documents and records to confirm the integrity of the Monash IVF record keeping systems relevant to the use of excess ART embryos authorised by Licence 309700. • Noted the full cooperation of Monash IVF which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Records Audit Inspection**
Licence Number	**309700**
Licence Holder	**Monash IVF (Queensland)**
Monitoring Activity Date	**15 April 2005**
Licence Title	Use of excess ART embryos for training in embryo biopsy.
Background	• On 11 March 2005, Monash IVF was issued with Licence 309700.
Inspector Activities Performed	• Inspected and examined relevant documents and records to confirm the integrity of the Monash IVF record keeping systems relevant to the use of excess ART embryos authorised by Licence 309700. • Noted the full cooperation of Monash IVF which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Monitoring Inspection**
Licence Number	**309708**
Licence Holder	**IVF Australia**
Monitoring Activity Date	**18 April 2005**
Licence Title	A collaborative project between IVF Australia and the Diabetes Transplant Unit, Prince of Wales Hospital to derive human embryonic stem cell lines for the treatment of diabetes.
Background	• On 5 November 2004, IVF Australia was issued with Licence 309708. • A Records Audit Inspection of Licence 309708 was conducted on 18 November 2004. • Based on the findings of the Records Audit Inspection, NHMRC Inspectors were satisfied that IVF Australia had complied with all legislative requirements.
Inspector Activities Performed	• Reviewed licensed activity 309708. • Inspected and examined relevant documents and records to confirm the integrity of the IVF Australia record keeping systems relevant to the licensed use of excess ART embryos in Licence 309708. • Traced all excess ART embryos used under Licence 309708 to the responsible persons and outcomes of the licensed use. • Noted the full cooperation of IVF Australia which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Monitoring Inspection**
Licence Number	**309704**
Licence Holder	**Melbourne IVF**
Monitoring Activity Date	**7 June 2005**
Licence Title	Development of testing procedures for unbalanced chromosome errors in human embryos.
Background	• On 16 April 2004, Melbourne IVF was issued with Licence 309704. • A Records Audit Inspection of Licence 309704 was conducted on 19 May 2004. • Based on the findings of the Records Audit Inspection, NHMRC Inspectors were satisfied that Melbourne IVF had complied with all legislative requirements.
Inspector Activities Performed	• Reviewed licensed activity 309704. • Inspected and examined relevant documents and records to confirm the integrity of the Melbourne IVF record keeping systems relevant to the licensed use of excess ART embryos in Licence 309704. • Traced randomly selected excess ART embryos used under Licence 309704 to the responsible persons and outcomes of the licensed use. • Noted the full cooperation of Melbourne IVF which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Monitoring Inspection**
Licence Number	**309709**
Licence Holder	**Melbourne IVF**
Monitoring Activity Date	**13 July 2005**
Licence Title	A collaborative project between Melbourne IVF Pty Ltd and Stem Cell Sciences Pty Ltd to derive human embryonic stem cell lines.
Background	• On 11 June 2004, Melbourne IVF was issued with Licence 309709. • A Records Audit Inspection of Licence 309709 was conducted on 20 July 2004. • A Monitoring Inspection of Licence 309709 was conducted on 23 November 2004. • Based on the findings of these monitoring activities, NHMRC Inspectors were satisfied that Melbourne IVF had complied with all legislative requirements.
Inspector Activities Performed	• Reviewed licensed activity 309709. • Inspected and examined relevant documents and records to confirm the integrity of the Melbourne IVF record keeping systems relevant to the licensed use of excess ART embryos in Licence 309709. • Traced randomly selected excess ART embryos used under Licence 309704 to the responsible persons and outcomes of the licensed use. • Noted the full cooperation of Melbourne IVF which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Monitoring Inspection**
Licence Number	**309701, 309702A, 309702B and 309703**
Licence Holder	**Sydney IVF**
Monitoring Activity Date	**11 August 2005**
Licence Title	309701: Improvement in laboratory conditions for embryo culture. 309702A: Effect of an additive on embryo culture: Analysis of growth and epigenetic programming. 309702B: Development of methods for pre-implantation genetic and metabolic evaluation of human embryos. 309703: Development of human embryonic stem cells.
Background	• On 16 April 2004, Sydney IVF was issued with Licences 309701, 309702A, 309702B and 309703. • A Records Audit Inspection of Licences 309701, 309702A, 309702B and 309703 was conducted on 4 May 2004. • A monitoring inspection of Licence 309703 was conducted on 29 June 2004. • Based on the findings of these monitoring activities, NHMRC Inspectors were satisfied that Sydney IVF had complied with all legislative requirements.
Inspector Activities Performed	• Reviewed licensed activities 309701, 309702A, 309702B and 309703. Inspected and examined relevant documents and records to confirm the integrity of the Sydney IVF processes for obtaining proper consent for the licensed use of excess ART embryos under these licences. • Traced excess ART embryos from selected patient records to proper consent. None of the excess ART embryos selected for tracking had been used during the reporting period. • Noted the full cooperation of Sydney IVF which provided all requested documentation and information. • Provided guidance to ensure continued compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping and reporting to the NHMRC Licensing Committee.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Monitoring Activity	**Short Notice Monitoring Inspection**
Licence Number	**309707**
Licence Holder	**Monash University**
Monitoring Activity Date	**15 August 2005**
Licence Title	Derivation of embryonic stem cell lines from the human embryo.
Background	• On 21 December 2004, Monash University was issued with Licence 309707. • A Records Audit Inspection of Licence 309707 was conducted on 3 February 2005. • Based on the findings of the Records Audit Inspection, NHMRC Inspectors were satisfied that Monash University had complied with all legislative requirements • On 9 August 2005, Monash University informed the NHMRC Licensing Committee that research authorised by Licence 309707 had commenced on 28 July 2005. • The NHMRC Licensing Committee had not received a report from Monash University before 28 July 2005 advising that proper consent had been obtained for the use of excess ART embryos from the responsible persons. • Consequently, NHMRC Inspectors resolved to conduct a Short Notice Monitoring Inspection of this licence to ensure that proper consent had been obtained.
Inspector Activities Performed	• Reviewed licensed activity 309707. • Inspected and examined relevant documents and records to determine whether proper consent for the use of the excess ART embryos under Licence 309707 had been obtained prior to their use. • Traced randomly selected excess ART embryos used under Licence 309707 to the responsible persons and outcomes of the licensed use. • Noted the full cooperation of Monash University which provided all requested documentation and information. • Provided further guidance to ensure compliance with licence conditions and legislation.
Conditions of Licence Findings	• Proper consent had been obtained for the use of each excess ART embryo in the authorised research before the research was commenced. However, due to an administrative oversight by the licence holder, the NHMRC Licensing Committee was not notified that proper consent had been obtained prior to the commencement of the research. • Monash University has appropriate systems and processes in place to ensure this incident is not repeated. • No other breaches of the legislation or licence conditions were discovered. • It was noted that Monash University fully cooperated with NHMRC Inspectors in the conduct of this short notice inspection.
***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	No breaches of the *Research Involving Human Embryos Act 2002* were detected.

Compliance Status	**Compliant.**

Monitoring Activity	**Monitoring Inspection**
Licence Number	**309707**
Licence Holder	**Monash University**
Monitoring Activity Date	**4 October 2005**
Licence Title	Derivation of embryonic stem cell lines from the human embryo.
Background	• On 21 December 2004, Monash University was issued with Licence 309707. • A Records Audit Inspection of Licence 309707 was conducted on 3 February 2005 with a satisfactory outcome. • On 15 August 2005, NHMRC Inspectors conducted a Short Notice Inspection of Licence 309707 in response to a failure by the Licence Holder to notify the NHMRC Licensing Committee that proper consent had been obtained prior to the use of excess ART embryos. • On 1 September 2005, the Chairman of the NHMRC Licensing Committee directed NHMRC Inspectors to conduct a Monitoring Inspection of Monash University to monitor procedures and processes to ensure all reporting requirements are met.
Inspector Activities Performed	• Reviewed licensed activity 309707. • Examined the processes implemented by Monash University to ensure that all reporting requirements are met. • Traced randomly selected excess ART embryos used under Licence 309707 to the responsible persons and outcomes of the licensed use. • Noted the full cooperation of Monash University which provided all requested documentation and information. • Provided further guidance to ensure compliance with licence conditions and legislation.

Conditions of Licence Findings	• Inspectors were satisfied that Monash University's procedures and processes will ensure that no excess ART embryos are used under Licence 309707 without notification of proper consent to the NHMRC Licensing Committee.
	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • proper consent;
	  • excess ART embryo tracking; and
	  • record keeping.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	No breaches of the *Research Involving Human Embryos Act 2002* were detected.
Compliance Status	**Compliant.**

Monitoring Activity	**Monitoring Inspection (Non-Licence Holder)**
Organisation	**Stem Cell Sciences Pty Ltd**
Monitoring Activity Date	**14 July 2005**
Background	• On 11 June 2004, Melbourne IVF Pty Ltd was issued with Licence 309709 titled 'A collaborative project between Melbourne IVF Pty Ltd and Stem Cell Sciences Pty Ltd to derive human embryonic stem cell lines'. • Licence 309709 authorises the removal of inner cell masses from excess ART embryos at Melbourne IVF and the transfer of these inner cell masses to Stem Cell Sciences where they will be cultured with the aim of deriving embryonic stem cells. • Stem Cell Sciences is not a licence holder but is authorised by Licence 309709 to participate in the licensed activity. • Special conditions 9302, 9303, 9402, 9502 and 9503 attached to Licence 309709 also apply to Stem Cell Sciences.
Inspector Activities Performed	• Obtained permission from Stem Cell Sciences to enter the premises for the purpose of monitoring compliance with the legislation and relevant licence conditions. • Noted the full cooperation of Stem Cell Sciences which provided all requested documentation and information. • Inspected and examined documents and records to confirm the integrity of the Stem Cell Sciences record keeping systems relevant to the licensed use of excess ART embryos in Licence 309709. • Traced all inner cell masses that had been transferred to Stem Cell Sciences from Melbourne IVF back to the patient records held at Melbourne IVF. • Provided guidance to ensure continued compliance with all legislative requirements.

Conditions of Licence Findings	• Inspectors were satisfied with the processes for meeting all conditions attached to the licence, including those relating to:
	  • excess ART embryo tracking between Melbourne IVF and Stem Cell Sciences; and
	  • record keeping.

***Prohibition of Human Cloning Act 2002* Findings**	There were no breaches of the *Prohibition of Human Cloning Act 2002* detected.
***Research Involving Human Embryos Act 2002* Findings**	There were no breaches of the *Research Involving Human Embryos Act 2002* detected.
Compliance Status	**Compliant**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-013

OUTCOME 11 – Health and Medical Research

Topic: LICENSING COMMITTEE

Written question on notice

Senator Fielding asked:

Please provide a copy of the legal advice received in relation to the newly created excess ART embryos, as mentioned in the Licensing Committee minutes of 1 June 2005.

Answer:

Legal advice provided to the National Health and Medical Research Council (NHMRC) is protected by legal professional privilege.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-003

OUTCOME 11 – Health and Medical Research

Topic: LICENSING COMMITTEE

Written question on notice

Senator Fielding asked:

What developments are there in the regulation of gene technology applying to humans? Please provide details.

Answer:

The *Prohibition of Human Cloning Act 2002* prohibits genetic modifications to human cells in a manner that would result in the modification being inherited by descendents of the person whose cell was modified.

The use of gene technologies and their products, including those that are applied**,** consumed by or administered to humans, is regulated in Australia under an integrated regulatory framework that comprises legislation administered by the Gene Technology Regulator, the Therapeutic Goods Administration, Food Standards Australia New Zealand, the Australian Pesticides and Veterinary Medicines Authority and the National Industrial Chemicals Notification and Assessment Scheme.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-010

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

What is the progress on developing a definition of embryo? Please provide a copy of the draft discussion paper mentioned in the Licensing Committee minutes of 1 June 2005.

Answer:

The discussion paper "Human Embryo – A Biological Definition" is currently being prepared for publication and a copy will be provided whin it is ready for publication.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-022

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

When will the Human Genetics Advisory Committee (HGAC) begin operating?

Answer:

The functions and composition of the HGAC were approved by the Minister for Health and Ageing on 2 November 2005. The HGAC will commence operation in 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-023

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

What will be the functions of the HGAC?

Answer:

The functions of the HGAC are:

The Human Genetics Advisory Committee, through the National Health and Medical Research Council, will provide on-going, high-level advice on:

- the technical and strategic aspects of current and emerging issues in human genetics and related technologies, particularly the expected impacts on human health and healthcare;
- the ethical, legal and social implications arising from developments in human genetics and related technologies, including consideration of any impact on human rights; and
- other matters as the Minister from time to time determines.

In exercising these responsibilities the Committee will provide:

- relevant expertise and a consultative mechanism for the development of policy statements and national guidelines in the area of human genetics and related technologies, where appropriate in association with other government agencies or the relevant industries and organisations;
- national leadership in the process of change relating to human genetics and related technologies, including engagement of the public on these issues;
- national leadership in identifying genetic tests that have particular concerns or sensitivities attached to them and thus may require special treatment;
- assistance with the development and coordination of community, school, university and professional education about human genetics;
- advice and a consultative mechanism to assist relevant bodies in identifying strategic priorities for research in human genetics and related technologies; and
- a focus for the coordination and integration of various national, regional and international programs and initiatives.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-024

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

When will the terms of reference and composition of the HGAC be released?

Answer:

See response to questions E05-000023 and E05-000025.

The Terms of Reference and Composition of the HGAC were made available on the NHMRC website on 4 November 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-025

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

What will be the composition of the HGAC? Will all stakeholders be represented? The UK's Human Genetics Commission- a comparable body-includes a consultative panel of people living with genetic disorders and their relatives. Will the HGAC have such a panel?

Answer:

The composition of the HGAC approved by the Minister for Health and Ageing on 2 November 2005 is:

The HGAC will be comprised of a Chairperson and up to 12 additional members with expertise covering the following areas:

- health and medical researchers, with an emphasis on human genetics;
- community representatives, including health consumer advocacy and genetic and disability support groups;
- business experts relevant to human genetics;
- medical practitioners with experience in health services;
- genetic counsellors;
- persons with experience in the ethics of health and medical research;
- lawyers with experience in privacy, discrimination and health law matters;
- science communicators;
- persons with experience in data management, health informatics or information security; and
- Aboriginal and Torres Strait Islander communities.

The membership will also:

- include at least one and no more than two from any of the above categories so as to be balanced and cover a broad-based range of expertise, experience and perspectives;
- be balanced as to gender and geographic distribution; and
- include a member in common with the Australian Health Ethics Committee (in accordance with subsection 36(2) of the *National Health and Medical Research Council Act 1992*).

The operation of the HGAC, including the need for a consultative panel, will be determined by the Committee in consultation with the Minister for Health and Ageing and the Council of the NHMRC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-026

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

The NHMRC has established a secretariat for the HGAC. When will this information be made public?

Answer:

The contact details for the HGAC secretariat were made available on the NHMRC website on 4 November 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-027

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

In order to promote public and professional confidence, the HGAC must maintain openness and transparency. How will this be ensured?

Answer:

The HGAC will operate as a Principal Committee of the National Health and Medical Research Council (NHMRC) including the normal consultation and reporting procedures used by the NHMRC and its committees.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-028

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

a) Will the HGAC be making recommendations to the Government on formulating guidelines to combat genetic discrimination and protect genetic privacy? If so, will the Government adopt these recommendations?

b) What likelihood is there of the Government adopting recommendations made by the HGAC?

Answer:

a) The workplan for the HGAC will be determined by the Committee in consultation with the Minister for Health and Ageing and the Council of the NHMRC. The Terms of Reference for the HGAC allow it to consider a wide range of matters, including matters that have been referred to the Committee by the Minister for Health and Ageing.
b) It will be a matter for the Government to decide on how it responds to any advice provided to it by the HGAC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-029

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

How will the HGAC balance maximising benefits from potential advances in human genetics with the ethical, legal and social implications of these advances?

Answer:

The HGAC will be comprised of persons with a wide range of experience and expertise. The HGAC will draw on this experience and expertise in providing advice on the ethical, legal and social implications of developments in human genetics and related technologies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-030

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE

Written Question on Notice

Senator Stott Despoja asked:

The "ALRC 96 Essentially Yours: The Protection of Human Genetic Information in Australia" report made 144 recommendations to formulate guidelines for protecting human genetic information, with its first being the establishment of a Human Genetics Advisory Commission. Will the Government be implementing more of the ALRC's recommendations? If so, which recommendations will be implemented and in what time frame?

Answer:

The Government released its response to the Australian Law Reform Commission (ALRC)/Australian Health Ethics Committee (AHEC) Report *Essentially Yours: The Protection of Human Genetic Information in Australia* on 9 December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-031

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

The Budget announcement of the HGAC provided the figure of $7.6million over four years. Will the funding be continued beyond four years? If so, how much funding will be allocated to the HGAC after four years?

Answer:

In line with Government policy, funding for the HGAC will be the subject of a lapsing program review in 2008 that will determine its future funding.