Community Affairs Legislation Committee

Examination of Budget Estimates 2009-2010

Additional Information Received
CONSOLIDATED VOLUME 1

HEALTH AND AGEING PORTFOLIO

Whole of Portfolio, Outcomes 1 to 15

20 OCTOBER 2009

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2009-2010

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the budget estimates hearings on 3 and 4 June 2009 and cross portfolio Indigenous issues hearing 5 June 2009

*** Please note that the tabling date of 29 October 2009 is the proposed tabling date**

HEALTH AND AGEING PORTFOLIO

Senator	Quest. No.	Whole of portfolio	Vol. 1 Page No.	Date tabled in the Senate or presented out of session*
Boyce	168, 320	Disabilities		20.08.09
Siewert	81, 82	Patents (epilepsy)		20.08.09
Boyce	120	Specific Purpose Payments to the States and Territories		20.08.09
Xenophon	122	Health and hospital funding		20.08.09
Boyce	171, 172	Freedom of Information		20.08.09
Boyce	280	External consultancies		20.08.09
Heffernan	309	Patents (Genes)		20.08.09
Heffernan	310	Patents over human genes		20.08.09
Heffernan	311	Patents (compulsory licences)		20.08.09
Heffernan	312	Gene patents (Crown use provisions)		20.08.09
Boyce	165	Services provided by AAP		20.08.09
Boyce	167	Staffing		20.08.09
Boyce	169	Percentages of superannuation		20.08.09
Boyce	170	Parental leave		20.08.09
Boyce	279	Consultancies		20.08.09
Boyce	281	External consultancies		20.08.09
Heffernan	313	Gene patents (economic analysis)		20.08.09
Boyce	166	Staffing		20.08.09
Cormann	121	Unsuccessful HHF applications		17.09.09
Adams	233, 236	Alcohol and drug strategy		01.09.09
Adams	234	Alcohol and drug strategy		17.09.09
		Outcome 1: Population Health		
		DoHA letter correcting evidence at hearing on 3.06.09 relating to data collected on number of people who need to be retested for bowel cancer screening		20.08.09
Cormann	60	Erythropoietin – applications to manufacture or produce		25.06.09
Cormann	61	Erythropoietin – applications to market generic version		25.06.09
Boyce	104	Bisephenola A		20.08.09
Ryan	41	National Men's Health Policy Ambassadors		20.08.09
Ryan	32, 149	Obesity		20.08.09
Ryan	29	Laparoscopic gastric banding		20.08.09
Ryan	31	Criteria for laparoscopic gastric banding		20.08.09

Brown, Carol	48-51	Solarium guidelines	20.08.09
Heffernan	316	Human gene therapy	20.08.09
Heffernan	317	Human gene testing	20.08.09
Heffernan	318	Gene patents - biopharmaceuticals	20.08.09
Brown, Carol	331	Solarium guidelines	20.08.09
Adams	248	Indigenous Tobacco Control Initiative (ITCI)	20.08.09
Adams	247	Indigenous health promotion	20.08.09
Ryan	13	Regulatory controls with cosmetic surgery	20.08.09
Barnett	144	National Partnership Agreement on Preventive Health	20.08.09
Adams	329	Alcohol resources	20.08.09
Ryan	46	Methicillin-Resistant Staphylococcus Aureus (MRSA) infection	20.08.09
Humphries	143	Preventative Health	20.08.09
Barnett	145	Preventative Health Taskforce	20.08.09
Barnett	145	Amended response – Preventative Health Taskforce	29.10.09
Heffernan	315	Hepatitis C tests	20.08.09
Humphries	146	Cervical cancer screening	17.09.09
Ryan	147	Bowel cancer screening	17.09.09
Adams	148	Bowel cancer screening	17.09.09
Ryan	336	Tobacco taxes	17.09.09

Outcome 2: Access to Pharmaceutical Services

Abetz	56	Introduction of novel medicines	20.08.09
Abetz	58	Unproven therapies	20.08.09
Ryan	42	PBS – price changes	20.08.09
Ryan	43	Brand premium	20.08.09
Ryan	44, 45	Special patient contribution	20.08.09
Abetz	55	Cost of the PBS oncology	20.08.09
Abetz	57	Introduction of novel medicines	20.08.09
Abetz	59	Oncology drug budget	20.08.09
Siewert	74	Fifth Community Pharmacy Agreement	20.08.09
Siewert	75	Approved pharmacies	20.08.09
Siewert	76	Pharmacies	20.08.09
Siewert	77	Pharmacists	20.08.09
Siewert	78	Pharmaceuticals in the NT	20.08.09
Barnett	138, 139	Insulin pump measure	20.08.09
Cormann	140, 141	Chemotherapy medicines	20.08.09
Adams	196	Chemotherapy drugs	20.08.09
Adams	197	Chemotherapy medicines	20.08.09
Adams	198	Chemotherapy drugs	20.08.09
Boyce	304	Juvenile insulin pumps for diabetes	20.08.09
Boyce	303	PBS savings	20.08.09
Ryan	330	PBS approval	20.08.09
Boyce	302	PBS reform	20.08.09

Outcome 3: Access to Medical Services

Ryan	28	Health Kids Check	20.08.09
Siewert	87	MSAC	20.08.09
Ryan	8, 9	Cosmetic surgery	20.08.09
Ryan	10	Medicare rebates – cosmetic surgery	20.08.09
Ryan	11, 12	Cosmetic procedures	20.08.09
Ryan	26	Healthy kids check	20.08.09
Boyce	305	Blood testing on pregnancies	20.08.09
Siewert	86	PET scanning	20.08.09
Siewert	88	PET scanning in Breast Cancer	20.08.09
Siewert	89	PET	20.08.09
Siewert	90	MSAC	20.08.09
Siewert	91	PET scanning	20.08.09
Siewert	92	PET data collection	20.08.09
Siewert	94	PET scan costs	20.08.09
Siewert	95	PET scanning	20.08.09
Siewert	193, 194	Medicare teen dental plan	20.08.09
Barnett	262	Positron Emission Tomography (PET)	20.08.09
Barnett	263	Report in relation to the Invitation to Apply (ITA) process for the provision of Medicare-eligible Magnetic Resonance Imaging (MRI) unit in north-west Tasmania	20.08.09
Siewert	261	Positron Emission Tomography (PET)	20.08.09
Barnett	264	Commitment of funds for a linea accelerator at Launceston Hospital	20.08.09
Ryan	7	Cosmetic surgery	20.08.09
Adams	221, 225	Cataract surgery	20.08.09
Barnett	259, 260	Cataracts	20.08.09
Siewert	333	Obstetrics	20.08.09
Ryan	27	Health kids check	20.08.09
Siewert	93	PET – lung cancer	20.08.09
Ryan	14	Cosmetic surgery	20.08.09
Heffernan	314	Hepatitis C testing	20.08.09
Ryan	30	Laparascopic gastric banding	20.08.09
Nash	103	Obstetrics MBS items	20.08.09
Barnett	266	WP Holman clinic	20.08.09
Adams	223, 224, 258	Cataract surgery	20.08.09
Barnett	257	Cataracts	17.09.09
Adams	222	MBS fee reduction	17.09.09
Siewert	85	Medical Services Advisory Committee (MSAC)	17.09.09
Barnett	265	Linear accelerator for Launceston	29.10.09

Outcome 4: Aged Care and Population Ageing

Adams	215	Aged Care	20.08.09
Xenophon	71	Non-compliance	20.08.09
Cormann	128, 135	Complaints investigation scheme	20.08.09
Humphries	137	Workforce	20.08.09
Ryan	20	Nursing home deaths	20.08.09
Xenophon	72	Four Corners	20.08.09
Cormann	129-131	Complaints investigation scheme	20.08.09
Adams	214	Ongoing care of residents following closure of residential aged care facilities	20.08.09
Ryan	18	Aged care homes under sanction	20.08.09
Williams	64	Residential aged care providers	20.08.09
Cormann	125	Complaints Investigation Scheme (CIS)	20.08.09
Adams	220	Community care	20.08.09
Cormann	338	Palliative care initiatives and funding sources for palliative care	20.08.09
Williams	63	Conditional adjusted payment percentage	20.08.09
Cormann	127, 132, 133, 134	Complaints investigation scheme	20.08.09
Adams	136	Aged care workforce	20.08.09
Adams	200	Residential aged care facilities	20.08.09
Adams	201	Residential care	20.08.09
Adams	203	Interest in the provision of residential aged care	20.08.09
Adams	204	Timing of the 2009-10 aged care allocation round	20.08.09
Adams	206, 207	Aged care workers	20.08.09
Adams	209	Aged care workforce	20.08.09
Adams	211	Dementia specific facilities	20.08.09
Adams	217	Community care places of Western Australia	20.08.09
Adams	218, 219	Community care packages	20.08.09
Cormann	270	Zero real interest loans	20.08.09
Cormann	271	Return on investment	20.08.09
Siewert	275	CAP review	20.08.09
Ryan	16	Residential aged care facilities	20.08.09
Ryan	19	Nursing home residents admitted to hospital	20.08.09
Adams	202	Aged care	20.08.09
Xenophon	269	Aged care funding growth	20.08.09
Cormann	272	Proportion of high care residents who rolled over from low care	20.08.09
Siewert	277	Exchange of places for community care packages	20.08.09
Ryan	17	Building and capital works	17.09.09
Williams	62	Aged care subsidies	17.09.09
Williams	66	Rehabilitation services	17.09.09
Adams	208, 213	Aged care	17.09.09
Adams	205, 212	Aged care	17.09.09
Adams	216	Aged Care Standards and Accreditation Agency	17.09.09
Xenophon	73	Auditor-General report	17.09.09
Fifield	268	Continence aids payment scheme	17.09.09

Adams	227	Elderly with poor vision	29.10.09
Fifield	267	Continence aids payment scheme	29.10.09
Boyce	278	Aged of bed allocations	29.10.09
Siewert	276	Regional breakdown of aged care approvals round places	29.10.09
		Letter from DoHA 19 Oct 09 correcting evidence given at hearing on 4 June 09 relating to Continence Aids Assistance Scheme	29.10.09

Outcome 5: Primary Care

Boyce	326, 327	General practice training locations	20.08.09
Boyce	328	General practice training in Indigenous health	20.08.09
Ryan	21	General practitioners	20.08.09
Ryan	22-25	GP super clinics	20.08.09
Ryan	34	Doctor numbers	20.08.09
Boyce	176	Practice Incentives Program (PIP) eHealth Incentive	20.08.09
Cormann	177	GP Assist	20.08.09
Adams	228	Service model trials	20.08.09
Adams	229	GP super clinics	20.08.09
Hanson-Young	96	Pregnancy counselling	20.08.09
Cormann	308	GP super clinics	29.10.09

Outcome 6: Rural Health

Adams	334	Rural Women's General Practice Service (RWAPS)	20.08.09

Outcome 7: Hearing Services

Back	99	Hearing services	20.08.09
Back	100	Hear and Learn	20.08.09

Outcome 8: Indigenous Health

Payne	152	Asbestos issues	20.08.09
Adams	154	Foetal alcohol syndrome	20.08.09
Back	97	Indigenous eye and ear health	20.08.09
Back	98	Hearing for Indigenous students	20.08.09
Payne	109	OATSIH's performance	20.08.09
Payne	110, 111	Aboriginal Medical Services	20.08.09
Payne	112	Community Controlled Health Services	20.08.09
Siewert	153	Narrogin and South West Aboriginal Medical Services	20.08.09
Siewert	155	Halls Creek service station and Opal fuel	20.08.09
Siewert	156	Alice Springs Opal fuel	20.08.09
Adams	235	Indigenous health	20.08.09
Adams	249	Health for Life program	20.08.09
Adams	250	Aboriginal Medical Services	20.08.09
Adams	251, 252	Healthy for Life	20.08.09
Adams	253-256	Narrogin	20.08.09

Boyce	306	Rheumatic heart disease	20.08.09
Payne	105	OATSIH funding	20.08.09
Payne	106, 107	Aboriginal Medical Service	20.08.09
Payne	108	OATSIH funding policy	20.08.09
Boyce	307	Child health checks	20.08.09

Outcome 9: Private Health

		Additional information provided by PHIAC on 3.06.09 relating to comparative industry margins comparing Mar 09 to Mar 08	25.06.09
Adams	199	Public hospitals	20.08.09
Cormann	179, 180	Private health insurance participation	20.08.09
Cormann	183, 186	Private health insurance	20.08.09
Cormann	182	Private health insurance rebates	20.08.09
Cormann	184	Private health insurance rebates	01.09.09
Cormann	185	Private health	01.09.09
Cormann	181	Private health	29.10.09

Outcome 10: Health System Capacity and Quality

		Letter dated 16 June 09 from National Breast and Ovarian Cancer Centre amending evidence provided at hearing 4 June 09 relating to media requests and interviews	25.06.09
Lundy	54	eHealth	20.08.09
Boyce	142	eHealth – NEHTA work due by end of 2009	20.08.09
Barnett	174, 175	Diabetes - research	20.08.09
Lundy	53	Individual electronic health records	20.08.09
Siewert	83	Gene mutations	20.08.09
Siewert	84	Genetic mutations test	20.08.09
Crossin	157	Asthma – Asthma friendly schools in the NT	20.08.09
Barnett	173	Diabetes – Life for Life program	20.08.09
Siewert	80	MS research	20.08.09
Boyce	114	Research	20.08.09
Siewert	115	Reporting	20.08.09
Siewert	116	Naltrexone trials	20.08.09
Adams	230	Don Nutbeam research	20.08.09
Boyce	294, 295	Research into H1N1	20.08.09
Adams	339	Gastric banding	20.08.09
Siewert	273	Benchmarking the cost of palliative care	20.08.09
Siewert	274	Palliative care initiatives and funding sources for palliative care	20.08.09
Lundy	52	eHealth	17.09.09
Adams	245	DoHA involvement in roll out of broadband	17.09.09
Boyce	293	Guidelines on Attention Deficit Hyperactivity Disorder (ADHD)	29.10.09

Outcome 11: Mental Health

Williams	65	Long term services for people with a mental illness and their carers	20.08.09
Williams	68	Mental health services for the aged population	20.08.09
Adams	226	Poor vision	20.08.09
Adams	231	Mental illness in rural areas	20.08.09
Humphries	340	Leadership in mental health reform	20.08.09
Boyce	296-299	Electroconvulsive therapy (ECT)	20.08.09

Outcome 12: Health Workforce Capacity

		Letter dated 22 June 09 from David Dennis, A/S Workforce Distribution Branch clarifying evidence provided at hearing on 4 June 09 relating to representations made by residents on Gawler	25.06.09
Nash	101	Medical workforce distribution	20.08.09
Williams	69	Mental health scholarships and graduates in rural areas	20.08.09
Humphries	321	Tracking of mental health scholarships	20.08.09
Williams	322	Age of rural and remote dentists	20.08.09
Humphries	335	Mental health nurse incentive program	20.08.09
Boyce	301	Scholarships and training programs	20.08.09
Ryan	15	Cosmetic surgeons	20.08.09
Adams	238	Bringing nurses back into the workforce	20.08.09
Adams	240	Nurses re-entering the workforce	20.08.09
Boyce	300	Nursing places	20.08.09
Adams	323	Nurse practitioners	20.08.09
Ryan	35	Doctor shortage	20.08.09
Ryan	36	Medical student graduates	20.08.09
Ryan	37	Hospital training places	20.08.09
Cormann	178	Specialist training in rural areas	20.08.09
Adams	232	Medical workforce	20.08.09
Adams	241	National health workforce agency	20.08.09
Adams	324	Bringing nurses back into the workforce	20.08.09
Williams	337	General Practitioners	20.08.09
Ryan	33	Overseas trained doctors	20.08.09
Adams	242-244	Overseas trained doctors	20.08.09
Adams	325	Expanding the specialist workforce to provide radiation oncology treatment	17.09.09
Nash	102	Medical workforce distribution	17.09.09
Adams	239	General practitioners	29.10.09

Outcome 13: Acute Care

Boyce	191	Commonwealth dental program	20.08.09
Adams	246	Dental services for Indigenous people	20.08.09
Boyce	289	Commonwealth dental program	20.08.09
Boyce	290	Medical indemnity program	20.08.09
Boyce	192	Commonwealth dental health program	20.08.09
Ryan	1	Organ transplantation	20.08.09
Ryan	2	Organ and tissue donation – waiting time deaths	20.08.09
Ryan	3	Organ transplantation	20.08.09
Ryan	4	Organ transplantation overseas	20.08.09
Ryan	5	Organs sent overseas	20.08.09
Ryan	6	Organ and tissue donation	20.08.09
Ryan	47	Methicillin-resistant staphylococcus aureus (MRSA)	20.08.09
Siewert	79	Health care agreements	20.08.09
Boyce	118	Organ donation	20.08.09
Siewert	119	Organ donation	20.08.09
Boyce	188	Performance indicators	20.08.09
Boyce	189	Hospital reporting	20.08.09
Boyce	195	Intergovernmental agreements	20.08.09
Boyce	283	Health and hospital funding	20.08.09
Boyce	284	OH&S in hospitals	20.08.09
Boyce	285	Hospitals	20.08.09
Boyce	286	Sub-acute care	20.08.09
Boyce	287	Hospital classification system	20.08.09
Boyce	288	Elective surgery	20.08.09
Boyce	291	National blood arrangements	20.08.09
Boyce	292	Transporting and supplying blood	20.08.09
Williams	190	Dental indicators	20.08.09
Cormann	123	NSW charging private hospitals for blood and blood products	20.08.09
		DoHA letter 07.07.09 correcting evidence provided at hearing 03.06.09 relating to the Commonwealth having legislative power to stop NSW imposing charges for blood	20.08.09
Williams	117	Organ donation	20.08.09
Boyce	187	Hospitals	20.08.09
Boyce	126	Infrastructure spending on public hospitals from HFF	20.08.09
Cormann	124	National blood arrangements	20.08.09
Boyce	282	Public hospitals	17.09.09

National Blood Authority

Letter dated 18 June 2009 from Dr Alison Turner, General Manager, National Blood Authority correcting evidence provided at the hearing on 3 June 2009	25.06.09
Letter from Octapharma Australia Pty Ltd dated 17 June 2009 commenting on evidence provided by NBA at the hearing on 3 June 2009	25.06.09

Outcome 14: Biosecurity and Emergency Response

Heffernan	319	Thermal scanners	20.08.09
Back	158	Dawn Princess – H1N1	20.08.09
Back	159	Pacific Dawn – H1N1	20.08.09
Back	162	National Action Plan – H1N1	20.08.09
Back	164	Hotline statistics – H1N1	20.08.09
Back	163	H1N1 influenza 09 – national medical stockpile	17.09.09

Outcome 15: Sport Performance and Participation

Fifield	113	AIS scholarships	25.06.09
Fifield	150	Independent sport panel	17.09.09
Fifield	151	Sport facilities	17.09.09
Adams	237	Sporting clubs and alcohol	17.09.09

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-168

OUTCOME 0: Whole of Portfolio

Topic: DISABILITIES

Hansard Page: CA 8

Senator Boyce asked:

How many people with disabilities are employed in the Department part time and full time?

Answer:

The total number of staff with disability (where information is volunteered) in the Department at 30 June 2009 was 169; 29 of whom were part time and 140 full time staff.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-320

OUTCOME 0: Whole of Portfolio

Topic: DISABILITIES

Hansard Page: CA 19

Senator Boyce asked:

What measures does the department have in place to encourage people with a disability to work in the department to further increase the number of people with a disability working for the department?

Answer:

The Department of Health and Ageing developed the Disability Action Plan 2008-2010 and has implemented a number of initiatives aimed at encouraging the employment of people with a disability.

The main objectives of the Disability Action Plan are:

1. Provide a positive and supportive work environment for people with disability;
2. Provide an accessible workplace for staff with disability;
3. Provide ready access to internal and external sources of information and assistance for staff with disability, their managers and co-workers;
4. Enhance career prospects, learning and retention for staff with disability;
5. Recognition of achievements and contributions;
6. Attracting applicants with disability.

The following initiatives have been implemented to encourage people with a disability to work in the Department:

- When advertising vacancies, the department acknowledges the importance of diversity and encourages applications from mature age workers, Aboriginal and Torres Strait Islander people, people with a disability as well as from diverse cultural backgrounds. Hearing and speech impaired applicants are encouraged to use the National Relay Service to obtain selection documentation and further information.
- In preparation for short listing, the applicant is asked to indicate in his/her application any reasonable adjustments that might be required to enable him/her to participate in an interview and work sample test.
- The Department has taken steps to improve the accessibility of all information on the

website. All website content is designed and constructed in accordance with the World Wide Web Consortium's Web Content Accessibility Guidelines.

- The Department is a member of the Australian Employers Network on Disability.
- The Department has appointed a Disability Champion to act as a senior level advocate for staff with disability.
- The Department conducts regular disability workforce information sessions aimed at all staff, covering topics such as mental health in the workforce and invisible disabilities.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-081

OUTCOME 0: Whole of Portfolio

Topic: PATENTS (EPILEPSY)

Written Question on Notice

Senator Siewert asked:

a) Is the Department aware of the Australian Patent 2001265698 entitled 'Mutations associated with epilepsy'?
b) Is the Department aware of Australian Patent 2004200978 entitled 'A diagnostic method for epilepsy'?
c) Is the Department aware that the owner of these two Australian patents is a South Australian company called Bionomics Limited?
d) Is the Department aware that both patents claim, as 'inventions', human DNA in an isolated form?

Answer:

a) Yes.

b) Yes.

c) This part seeks information about patents and patenting practices, which is a matter for IP Australia.

d) This part seeks information about patents and patenting practices, which is a matter for IP Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-082

OUTCOME 0: Whole of Portfolio

Topic: PATENTS (EPILEPSY - SYDNEY MORNING HERALD MEDIA ARTICLE)

Written Question on Notice

Senator Siewert asked:

a) Is the Department aware that on 29 November 2009 the *Sydney Morning Herald* published an article which ran the headline 'Sick babies denied treatment in DNA row'?

b) If so, has the Department responded and in what form has the response taken?

Answer:

a) Yes.

b) No. However, the Department notes that at the public hearing for the Senate Community Affairs Committee Inquiry into Gene Patents, on 19 March 2009, Senator Catryna Bilyk raised some questions concerning the gene, SCN1A, and its association with Dravet Syndrome. On 23 April 2009, the National Health and Medical Research Council Chief Executive Officer provided a response to those questions to the Senate Committee.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-120

OUTCOME 0: Whole of Portfolio

Topic: SPECIFIC PURPOSE PAYMENTS TO THE STATES AND TERRITORTIES

Hansard Page: CA 120-125

Senator Boyce asked:

Under the Federal financial framework, which payments to the States and Territories are automatic and which are performance based?

Answer:

Payments relating to the Health Portfolio are detailed in the tables below. Payments are either facilitation (automatic) payments, or reward (incentive) payments. Under the new streamlined Federal Financial Relations arrangements, copies of national partnerships and attached implementation plans are available at www.coag.gov.au

National Health Care Agreement

Program	*Payment Type*
National Health Care Agreement SPP	Facilitation payment

National Partnership on Preventive Health

Program	*Payment Type*
Healthy Children Program	50% facilitation payment 50% reward payment
Healthy Workers Program	50% facilitation payment 50% reward payment
Social Marketing Program	Facilitation payment
Enabling Infrastructure Program	Facilitation payment

National Partnership on Hospital and Health Workforce Reform

Program	*Payment Type*
Activity Based Funding	Facilitation payment
Workforce Enablers	Not applicable
Subacute Care	Facilitation payment
Taking Pressure off Public Hospitals	Facilitation payment

National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes

Program	*Payment Type*
National Partnership Agreement on Closing the Gap in Indigenous Health Outcomes	Not applicable

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-122

OUTCOME 0: Whole of Portfolio

Topic: HEALTH AND HOSPITAL FUNDING

Hansard Page: CA 32

Senator Xenophon asked:

What are the indexation arrangements for the health and hospital system under the COAG negotiation?

Answer:

As stated in Schedule D to the Intergovernmental Agreement on Federal Financial Relations, the growth factor for the National Healthcare specific purpose payment will be the product of:

(a) a health specific cost index (the Australian Institute of Health and Welfare health price index);

(b) growth in population estimates weighted for hospital utilisation; and

(c) a technology factor (Productivity Commission derived index of technology growth).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-171

OUTCOME 0: Whole of Portfolio

Topic: FREEDOM OF INFORMATION

Hansard Page: CA 9

Senator Boyce asked:

a) How long has the Department had the FOI requests that decisions have not been made on?
b) What is the longest outstanding FOI request that is undecided?
c) What is the breakdown in months outstanding eg how many are more than nine months outstanding etc?

Answer:

a - c)

The Department had 40 FOI requests with decisions outstanding as at 3 June 2009. Of those 40 requests outstanding, no decisions were overdue. All 40 requests were being processed within the 30 day timeframe or 60 day timeframe (where statutory consultation is required) as required under the *Freedom of Information Act 1989*.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-172

OUTCOME 0: Whole of Portfolio

Topic: FREEDOM OF INFORMATION

Hansard Page: CA 9-10

Senator Boyce asked:

How would you characterise FOI applications which are refused in that they are not given any information at all?

Answer:

Of 201 requests received by 3 June 2009, the department had refused access in full to documents requested in 11 FOI requests. Eight of the 11 requests where access was refused in full came from innovative pharmaceutical companies seeking to verify through the FOI process that a generic pharmaceutical company had lodged applications to the Therapeutic Goods Administration for registration of drugs. The documents found within the scope of those requests contained information that relate to the business or commercial activity of a third party of which the value of the information could reasonably be expected to be destroyed or diminished if it were disclosed.

Two requests where access was refused in full sought a voluminous amount of documents which would have been an unreasonable diversion of the department's resources to process the request. On both occasions the applicants were provided the opportunity to reduce the scope of their request.

For the remaining request where access was refused in full, the applicant had sought documents for which the release would have divulged information which was communicated in confidence to the Commonwealth by or on behalf of a state or territory Government.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-280

OUTCOME 0: Whole of Portfolio

Topic: EXTERNAL CONSULTANCIES

Written Question on Notice

Senator Boyce asked:

Can the Department provide a list of all organisations and individuals employed as external consultants in 2008-09?

Answer:

The following table contains a list of 187 organisations and individual entities that operated as external consultants to the Department of Health and Ageing in 2008-09.

Please Note: Given resource and timing constraints, it is not possible to list all the specified consultants engaged through these entities.

Consultancy Organisations
20/20 Integrated Solutions Pty Ltd
Accenture Australia Holdings Pty Ltd
Access Economics
Allan Lindsay Black
Allen and Clarke Policy and Regulation Specialists
Allen Consulting Group
Alliance of NSW Division Ltd
Apis Consulting Group
Apis Group Pty Ltd
AProf Danny Liew
ARTD Pty Ltd
Ascent Consulting Pty Ltd
Australian Bureau of Statistics VIC
Australian National University - University House
Australian Drug Foundation Inc
Australian Government Actuary
Australian Government Solicitor
Australian Healthcare and Hospitals Association
Australian Healthcare Associates Pty Ltd
Australian Hearing Services
Australian Indigenous Business Services Pty Ltd

Consultancy Organisations
Australian Institute of Health and Welfare
Avanade Australia Pty Ltd
Banscott Health Consulting Pty Ltd
Barbara Schmidt & Associates Pty Ltd
Basso Newman & Co
Blue Moon Unit Trust
Brett Lennon
C3 Business Solutions Pty Ltd
Campbell Research & Consulting Pty
Carroll Communications Pty Ltd
Centre for International Economics
Centre for Public Management
CGF Phoenix Pty Ltd
Charles Darwin University
Christopher John Emery Kooya Consulting
Claire Caesar
Claire Jackson
Clayton Utz
Coffey Projects (Australia) Pty Ltd
Communio Pty Ltd
Consultants in Health Service Development (CHSD) Pty Ltd
Coote Practice Pty Ltd
David William Lyle Webster
Deakin University
Deloitte Touche Tohmatsu
Department of Education & Early Childhood Development
Department of Health & Ageing - CPM Centre
Diabetes Australia Ltd
DLA Phillips Fox
Doll Martin Associates Pty Ltd
Donald James St John
DSI Consulting Pty Ltd
Edith Cowan University
Ernst & Young
Evolution Research Pty Ltd
Ewan Maxwell Morrison
Fianian Pty Ltd
Flinders Consulting Pty Ltd
Flinders University
Food Science Australia
Frontier Group Australia Pty Ltd
G J Wall and Associates
Gevers Goddard-Jones Pty Ltd
Graham Martin
Grass Roots Contracting
Griffith University
GSB Consulting and Communications Pty Ltd
Health Informatics Society of Australia
Health Outcomes International Pty Ltd
Health Policy Analysis Pty Ltd
Healthcare Management Advisors Pty Ltd

Consultancy Organisations
Healthcare Planning & Evaluation
Healthconsult Pty Ltd
Heathmore Pty Ltd
Horizon Research
Human Capital Alliance (International) Pty Ltd
I I R Pty Ltd
Ian R. Falconer Water Quality Consultant
IMS Health Australia Pty Ltd
Institute for Healthy Communities Australia Ltd
Integrated Planning Solutions
Interflu Pty Ltd
International Diabetes Institute
Ipsos Public Affairs Pty Ltd
J Cornish and Associates Pty Ltd
Jacara Consulting
Jamieson Foley
Jing Jing Li
John Humphreys
John McEwen
John Stewart Deeble
John Wakerman
JTA International Pty Ltd
Judith Margaret Dwyer
KPMG
Kristine Battye Consulting Pty Ltd
La Trobe University
Leeden Associates Pty Ltd
Lesley Russell
Lewis Troutman And Associates Pty Ltd
Linda M Webb
Little Oak Pty Ltd
London School of Hygiene & Tropical Medicine
M Love & D Toole & J.S Wilson
Mallesons Stephen Jacques
Mark Williams Management Pty Ltd
Matthews Pegg Consulting Pty Ltd
McArthur Management Services (NSW) Pty Ltd
McArthur Management Services (SA) Pty Ltd
Menzies School of Health Research
Minter Ellison
Monash University
Morison Consulting Pty Ltd
MSR Consulting Pty Ltd
M-Tag Pty Ltd
National Ageing Research Institute Inc
National Association of Testing Authorities Australia
National Breast & Ovarian Cancer Centre
National Institute of Labour Studies Inc
Noetic Solutions Pty Ltd
Nous Group Pty Ltd
Oakton AA Services Pty Ltd

Consultancy Organisations
Ochre Health Pty Ltd
Office of the Privacy Commissioner
Oliver Winder Pty Ltd
OOSW Consulting Pty Ltd
ORC Australia Pty Ltd
Orygen Research Centre
Osteoporosis Australia
Ott-Line Enterprises
Parsons Brinckerhoff Australia Pty Ltd
PCA People Pty Ltd
Peter James Abbott
Phillip Jones & Associates Pty Ltd
PPB Pty Ltd
PriceWaterhouseCoopers Actuarial Pty Ltd
Profile Ray and Berndtson Pty Ltd
PSND Consulting Pty Ltd
Public Health Association of Australia Inc
Quality Improvement Council Ltd
Quantum Consulting Australia Pty Ltd
Queensland University Of Technology
Resolution Consulting Services Pty Ltd
Robert Griew Pty Ltd
Robin Hill Health Pty Ltd
Rossarden Pty Ltd
Royal Australasian College Of Surgeons
Shannon Consulting Services Trust
Siggins Miller Consultants Pty Ltd
SMS Consulting Group Ltd
South Australian Centre for Economic Studies
Stancombe Res & Planning Pty Ltd
Stay Tuned Productions Pty Ltd
Synergy Business Solutions
Synertec Pty Ltd
Tarcus Pty Ltd
Templeton Galt Pty Ltd
The Adelaide Research & Innovation Investment Trust
The Social Research Centre Pty Ltd
The Trustee for Anglesea Unit Trust
The Trustee for Charter Mason Services Trust
Thomas Whayman & McCarthy
Toxikos Pty Ltd
University of Canberra
University of Melbourne
University of Newcastle
University of NSW
University of Queensland
University of South Australia
University of Sydney
University of Technology, Sydney
University of Western Australia
University of Western Sydney

Consultancy Organisations
University of Wollongong
University Physicians Inc
UNSW Global Pty Ltd
Urbis Pty Ltd
UTAS Innovation Ltd
Utilities Holdings Pty Ltd
Valintus Pty Ltd
Victorian Health Promotion Foundation - VIC Health
VT Coach Pty Ltd
Wallace MacKinnon & Associates Pty Ltd
Walter Turnbull Pty Ltd
Woolcott Research Pty Ltd
XIP Pty Ltd

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-309

OUTCOME 0: Whole of Portfolio

Topic: PATENTS (GENES)

Written Question on Notice

Senator Heffernan asked:

A study published in Science in 2005 showed that at least 20% of the human genome (which is made up of about 23,000 genes) was the subject of US patents.

a) Does the Department know how many of these kinds of patents have been granted by IP Australia?

b) If so, how many and over what human genes do they apply?

Answer:

a) This question seeks information about patents and patenting practices, which is a matter for IP Australia.

b) Refer to part a).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-310

OUTCOME 0: Whole of Portfolio

Topic: PATENTS OVER HUMAN GENES

Written Question on Notice

Senator Heffernan asked:

a) Has the Department undertaken any study or analysis of the cost to this country's healthcare system of patents over human genes?
b) If so, elaborate. If not, are there any plans to do so? If no, why not?

Answer:

a) The Department undertook analysis of these issues to inform its submission to the Australian Law Reform Commission (ALRC) inquiry which led to the ALRC's 2004 Report *Genes and Ingenuity: Gene Patenting and Human Health*. The terms of reference for this inquiry required the ALRC to report on, among other things, the impact of current patenting laws and practices related to genes and genetic and related technologies on the cost-effective provision of healthcare in Australia.

b) Refer to part a).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-311

OUTCOME 0: Whole of Portfolio

Topic: PATENTS (COMPULSORY LICENCES)

Written Question on Notice

Senator Heffernan asked:

a) Has the Department ever applied for a compulsory license with respect to any Australian patent that includes within the scope of the patent monopoly a human gene product of that gene?
b) If so, elaborate. If not, why not?

Answer:

a) No.

b) The Department has not sought agreement from the Minister to exploit any invention through compulsory licensing provisions under section 133 of the *Patents Act 1990*. This action has not been necessary to achieve affordable access to healthcare.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-312

OUTCOME 0: Whole of Portfolio

Topic: GENE PATENTS (CROWN USE PROVISIONS)

Written Question on Notice

Senator Heffernan asked:

a) Has the Department ever invoked the Crown Use provision (s.163(1) Patents Act, 1990) with respect to any Australian patent that includes within the scope of the patent monopoly a human gene or a product of that gene?

b) If so, elaborate. If not, why not?

Answer:

a) No.

b) The Department has not sought agreement from the Minister to exploit an invention by the crown under section 163 of the *Patents Act 1990*. This action has not been necessary to achieve affordable access to healthcare.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-165

OUTCOME 0: Whole of Portfolio

Topic: SERVICES PROVIDED BY AAP

Hansard Page: CA 9

Senator Boyce asked:

Is the wire service provided by AAP for assent, distribution or both?

Answer:

The wire service is for the receipt of news only.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-167

OUTCOME 0: Whole of Portfolio

Topic: STAFFING

Hansard Page: CA 9

Senator Boyce asked:

Does the Department publish the number of people with disabilities employed within the department?

Answer:

The number of ongoing staff with disability in the department is published in the State of the Service report each financial year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-169

OUTCOME 0: Whole of Portfolio

Topic: PERCENTAGES OF SUPERANNUATION

Hansard Page: CA 9

Senator Boyce asked:

What rates of superannuation are paid to DoHA staff?

Answer:

The employer superannuation contribution rates for financial year 2008-09 were:

- Commonwealth Superannuation Scheme (CSS) – 25.1%
- Public Sector Superannuation Scheme (PSS) – 13.2%
- Public Sector Superannuation Accumulation Plan (PSSap) – 15.4%
- Other Superannuation Funds – 15.4%

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-170

OUTCOME 0: Whole of Portfolio

Topic: PARENTAL LEAVE

Hansard Page: CA 8

Senator Boyce asked:

The number of men/women who utilised parental leave?

Answer:

A total of 58 staff utilised parental leave in financial year 2008-09, of whom 56 were men and two were women.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-279

OUTCOME 0: Whole of Portfolio

Topic: CONSULTANCIES

Written Question on Notice

Senator Boyce asked:

The Department spent $17.51 million on external consultancies in 2007-08. What does the Department estimate will be the cost of external consultancies used in 2008-09 and 2009-10?

Answer:

As reported in the Department of Health and Ageing 2007-08 Annual Report, 450 new consultancy contracts were entered into involving expenditure of $17.51 million (GST inclusive). In addition, 187 ongoing consultancy contracts were active during the year involving expenditure of $15.45 million (GST inclusive).

Total expenditure on external consultancies in 2007-08 was $32.96 million (GST inclusive).

As at 1 July 2009, final 2008-09 consultancy expenditure totals were not available. The total cost of 2008-09 external consultancies is, however, estimated to be $27.81 million (GST inclusive).

Based on the three most recent financial years, the expenditure on consultancies in 2009-10 is estimated to be $31.9 million (GST inclusive).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-281

OUTCOME 0: Whole of Portfolio

Topic: EXTERNAL CONSULTANTS

Written Question on Notice

Senator Boyce asked:

The Department employs external consultants in cases where the Departmental staff do not have the necessary skills in professional health issues to undertake reviews, reports, etc

a) Can the Department provide a list of any training programs to equip employees with these skills, and the number of employees undertaking each program in 2008-09?
b) Can the Department provide the cost of such training programs in the 2008-09 year?

Answer:

a) The majority of reviews undertaken within the Department relate to lapsing program evaluations. Such evaluations would not typically be undertaken by departmental staff. Accordingly, the use of external consultants is appropriate for this activity and as such, there is no requirement to train departmental staff in this regard.

b) Not applicable

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-313

OUTCOME 0: Whole of Portfolio

Topic: GENE PATENTS (ECONOMIC ANALYSIS)

Written Question on Notice

Senator Heffernan asked:

a) Has the Department ever conducted an economic analysis of the impact of gene patents granted by IP Australia on the cost of healthcare?
b) If so, elaborate. If not, is the Department considering having such an analysis conducted? If not, why not?

Answer:

a) The Department undertook analysis of these issues to inform its submission to the Australian Law Reform Commission (ALRC) inquiry which led to the ALRC's 2004 Report *Genes and Ingenuity: Gene Patenting and Human Health*. The terms of reference for this inquiry required the ALRC to report on, among other things, the impact of current patenting laws and practices related to genes and genetic and related technologies on the cost-effective provision of healthcare in Australia.

b) Refer to part a).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-166

OUTCOME 0: Whole of Portfolio

Topic: STAFFING

Hansard Page: CA 9

Senator Boyce asked:

How many contractors are employed by the Department?

Answer:

As at 30 June 2009 there were 139 contractors engaged by the Department of Health and Ageing who operated in positions that would otherwise be occupied by APS employees.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-121

OUTCOME 0: Whole of Portfolio

Topic: UNSUCCESSFUL HHF APPLICATIONS

Hansard Page: CA 16

Senator Cormann asked:

Can you provide a list of the projects that were considered by the HHF and the reasons why those unsuccessful projects were rejected?

Answer:

It is not possible to provide a list of projects that were considered by the HHF Advisory Board as the reasons why unsuccessful projects were rejected are confidential to the applicants and also form part of Government deliberations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-233

OUTCOME 0: Whole of Portfolio

Topic: ALCOHOL AND DRUG STRATEGY

Written Question on Notice

Senator Adams asked:

If you have consulted youth groups, have you gone to different cultures, socio-economic groups, age groups etc?

Answer:

The National Binge Drinking Campaign has been informed by a range of research including formative research conducted on behalf of the Department as well as learnings from previous Government alcohol campaigns. Young people were consulted as part of campaign development research process.

The creative concepts (television, radio, print, outdoor and online) underwent a number of rounds of concept testing and refinements with young people to ensure that the creative approach was credible to the target audiences and fulfils the campaign objectives. The sample of the formative and developmental research contained a range of cultures, socio-economic groups, geographic locations and target audiences ages.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June, 2009

Question: E09-236

OUTCOME 0: Whole of Portfolio

Topic: ALCOHOL AND DRUG STRATEGY

Written Question on Notice

Senator Adams asked:

Is it possible that 'hard hitting adverts' are not affecting young people whose senses are possibly dulled to shock tactics?

Answer:

The National Binge Drinking Campaign (NBDC) was underpinned by comprehensive formative research and concept testing that found the advertisements were seen to be realistic, relevant, credible and effective. The target audiences also felt that the consequences portrayed are serious and likely to occur after drinking to intoxication.

The approach adopted for the NBDC, which accurately depicts the consequences of binge drinking, was necessary to convey the serious nature of the harm associated with drinking to intoxication as well as to increase the target audiences' ability to relate to the scenarios and reconsider their drinking behaviours.

Fear appeals and hard hitting or shock tactics are commonly used in health promotion and social marketing campaigns. They are effective when the threat of a portrayed consequence is seen by the target audience as likely to occur and serious, and the behaviour required to reduce or avoid the risk of this consequence is seen as simple, achievable and effective.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June, 2009

Question: E09-234

OUTCOME 0: Whole of Portfolio

Topic: ALCOHOL AND DRUG STRATEGY

Written Question on Notice

Senator Adams asked:

a) Where is most promotion for young people placed? Eg. schools, TV, pubs, etc.
b) What percentages of young adults are watching this promotion and reacting positively to it, ie reducing their drinking amounts?
c) What are you using to ensure your figures are correct?

Answer:

a) The National Binge Drinking Campaign utilised television, radio, print, cinema and online advertising.

b) The Government's master media buying agency, Universal McCann, has advised that approximately 90% of the target audience (youth aged 15-25 years) was exposed to the campaign advertising. This figure represents the combined exposure rate of all media used in the campaign. However, as some media do not measure reach, the percentage of the target audience exposed to the campaign will never be completely accurate. The campaign evaluation has not been finalised.

c) Research is conducted to ensure, as far as possible, that the messaging and communication is reaching the target audience.

Australian Government

Department of Health and Ageing

Mr Elton Humphrey
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphrey

Request for Amendment to Evidence Provided at the Senate Community Affairs Committee Budget Estimates Hearing, 3 June 2009: Outcome 1

I am writing to correct a statement I made at the Budget Estimates hearing of the Senate Community Affairs Committee on 3 June 2009.

Senator Ryan asked the following question at CA95:

"Following up on that, are you collecting data on the number of people who need to be retested?"

My response was as follows:

"The number that need to be retested is 389,911 people."

In light of subsequent advice, I ask that my statement be amended as follows (changes underlined):

"As at 28 May 2009, the number who will need to be retested is estimated to be around 384,837 people."

Yours sincerely

Peter Morris
Assistant Secretary
Population Health Strategy Unit

23 July 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-060

OUTCOME 1: Population Health

Topic: ERYTHROPOIETIN - APPLICATION TO MANUFACTURE OR PRODUCE

Written Question on Notice

Senator Cormann asked:

Has the Therapeutic Goods Administration received an application(s) to manufacture or produce the biopharmaceutical erythropoietin in Australia? If so, elaborate.

Answer:

Manufacturing licences are granted under section 38 of the *Therapeutic Goods Act 1989* for the manufacturing steps and dosage forms to be undertaken at a particular site. No applications have been received to grant a manufacturing licence in Australia for the manufacture of the biopharmaceutical erythropoietin.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-061

OUTCOME 1: Population Health

Topic: ERYTHROPOIETIN - APPLICATIONS TO MARKET GENERIC VERSION

Written Question on Notice

Senator Cormann asked:

Has the TGA received an application(s) for the marketing of a generic version of the biopharmaceutical erythropoietin? If so, elaborate.

Answer:

Yes. An application to register a generic (or "biosimilar") version of epoetin alfa (EPREX) is currently under evaluation by the TGA. It was considered by the Australian Drug Evaluation Committee (ADEC) at its meeting on 5 June 2009. ADEC recommended approval of the application.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-104

OUTCOME 1: Population Health

Topic: BISPHENOL A

Hansard Page: CA 115

Senator Boyce asked:

Would FSANZ provide advice on the following:

a) Can FSANZ quantify the amount of Bisphenol A a baby could ingest using a bottle or cup?
b) Can FSANZ advise on what would be considered a safe level for ingestion of Bisphenol A?
c) In relation baby bottles and cups, are any manufactured in Australia or New Zealand?

Answer:

a) Recent assessments published by regulatory agencies in Europe, the United States of America (USA) and Canada have investigated the amount of bisphenol A (BPA) that infants and children could ingest from food and drink. Estimated intakes were expressed relative to bodyweight (i.e. per kilogram). FSANZ has reviewed these assessments and concluded that the highest intake of BPA in infants and children would be very unlikely to exceed **13 micrograms per kg bodyweight per day**.

b) The tolerable daily intake (TDI) of a contaminant in food or drink is defined as the amount that can be ingested daily for a lifetime without posing a significant risk to health. The TDI therefore represents a safe level of ingestion. The TDI for BPA, as established by European and USA regulatory authorities, is **50 micrograms per kg body weight per day**. Health Canada has established a provisional TDI of 25 micrograms per kg body weight per day. FSANZ has not formally established a TDI for BPA but is in agreement with the value of 50 micrograms per kg body weight per day established by Europe and the USA. The highest estimated BPA intake for infants and children (13 micrograms per kg bodyweight per day) is well below the TDI of 50 micrograms per kg body weight per day.

c) FSANZ has not identified any BPA-containing baby bottles or cups as being manufactured in Australia. Information on this matter was obtained from manufacturers, retailers and several organisations including the Australian Food and Grocery Council. While it is possible that such baby bottles or cups may be sold in specialty stores, FSANZ considers that the vast majority are manufactured overseas.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-041

OUTCOME 1: Population Health

Topic: NATIONAL MEN'S HEALTH POLICY AMBASSADORS

Written Question on Notice

Senator Ryan asked:

a) What activities have the Men's Health Ambassadors announced by Minister Roxon on 25 November 2008, undertaken on behalf of the Department since this date?

b) Can the Department supply transcripts of speeches and interviews given by these Ambassadors?

c) What costs have been incurred by each Ambassador, in terms of any remuneration, travel, allowance, hospitality, administrative and any other costs?

Answer:

a) The Men's Health Ambassadors have participated in the National Men's Health Policy Roundtable held at Parliament House on 19 March 2009, and in National Men's Health Policy Consultation Forums held across the country between February and June 2009.

b) The keynote speech given by the Governor of Victoria, His Excellency Professor David de Kretser at the National Men's Health Policy Roundtable is at Attachment A. The Department does not have any other transcripts of speeches given by the Men's Health Ambassadors. At the National Men's Health Policy Consultation Forums, the Ambassadors gave informal talks about what men's health means to them. These talks have not been recorded.

c) The Department has met the Ambassadors' travel costs associated with attending the National Men's Health Policy Roundtable and the National Men's Health Policy Consultation Forums. Approximate travel costs for each Ambassador up to 30 June 2009 are:

Professor David de Kretser:	Nil
Professor John Macdonald:	$2,647.00
Mr Tim Mathieson:	$3,920.00
Mr Bill Noonan:	$2,096.00
Mr Barry Williams:	Nil

Attachment A
National Men's Health Roundtable Keynote Speech
His Excellency Professor David de Krester

Men's Health: What men's health means to me?

National Men's Health Roundtable, Parliament House Canberra
Thursday 19th March 2009

Acknowledgments

Honorable Nicola Roxon, Minister for Health

Speech

Men's Health Ambassadors,
Distinguished Guests, Ladies and Gentlemen

Thank you for the opportunity to join you for this Men's Health Summit. Let me say at the outset that the documentation provide clearly outlines the importance of social determinants of Men's Health and links policies in this area to policies involved with Education, Employment, Housing and Communities. For reasons that I will outline, Men's Health Policies need to interface with polices also for Maternal Health, Child Health and Environmental Health.

Finally, I would like to make a plea that we do not develop policy on what we know now but on emerging data that will influence policies into the future. To answer the question of what men's health means to me, I need to give you an idea of what I think is the optimum health status for a man. I like to define this as :
"The optimum state of mind and body that enables a man to engage fully with his family and the society in which he lives for at least the average life expectancy of the male population"

Let me take you on a rapid journey to explore the factors, of which we are aware currently, that may impact on this optimum state of health and it will become clear that this involves an important mix of biological and psycho-social issues, in other words the basis of an holistic men's health policy, which if it is to be delivered successfully, must interface with optimal maternal and child health.

The reason for mentioning maternal and child health is the rapidly accumulating data that events during fetal life, childhood and adolescence can have major impact on adult health and thus a men's health policy.

Men are different. The look different, they have different genitalia, they react differently, they suffer from diseases that are uniquely male such as prostate disease or erectile dysfunction, and they also have greater risks of certain diseases that affect both men and women. So why these differences?

Perhaps the most fundamental factor that is with us from the start of life is our genes or our genetic constitution. The egg and the sperm bring genetic material that constitutes each man's genome. Men have an X and Y sex chromosomes with the Y inherited from the father and the X from the mother.

The Y chromosome drives the formation of the testis and in turn the masculine genitals.

The genetic material present in the fertilised egg establishes the genetic template that determines a person's sex and also their genetic propensity for disease, both of which moulded by a series of factors.

What are the factors that can interact with a man's genome to determine health ?

- Your genes establish your sex and your propensity to succumb to disease
- The expression and function of this genetic background is conditioned by life in the womb, your "conditioning" by your family, your education and your lifetime experiences
- Your societal experience can influence your approach to health, namely by peer pressure and conditioning
- Your environmental exposure can influence a number of disease processes and new evidence indicate these influences can be transmitted to the next generation by causing mutations in genes but also by changes that do not alter your genetic code but may alter the relative expression of certain genes, a rapidly growing area of science called epigenetics
- Finally, there are gender specific diseases that relate to male reproductive organs, and those that are termed non-gender specific, that affect organs common to both men and women, although these disease processes can show differing frequencies and severities between sexes.

I mentioned earlier that the environment to which an individual is exposed may influence their health. We have many well known examples such as the exposure to asbestos causing the development of mesothelioma of the lungs and the development of pulmonary fibrosis in miners exposed to coal mining dusts.

What is less recognised is the influence of parental exposure to environmental toxicants and their influence on future generations through epigenetic influences. I will just mention one example. The Serveso Incident arising from a factory explosion exposed a significant population in central Europe to dioxin. For many years later, those couples closest to the explosion had a distortion of the sex ratio of children born such that the number of male children born decreased to approximately 35% compared to an almost 50/50 ratio.

There is increasing recognition that intra-uterine life can influence the health of children well into their adult years. Fetal exposure to alcohol through maternal drinking is well established to cause the "fetal alcohol syndrome". Less well recognised is a set of disorders that are attributed to intra-uterine influences for which the mechanisms are, as yet, unclear. These form the basis of the Barker Hypothesis which links under nutrition in utero, leading to low birth weight, with an increased risk of hypertension, coronary artery disease, stroke, diabetes and the metabolic syndrome in adulthood.

Postnatal development, infancy and childhood experiences are increasingly being recognised as important in the development of the brain and the behavioural patterns. Less than optimal parenting and education may affect the intellectual development and capacity of an individual to interact with society.

Parental example can influence attitudes to the development of healthy life styles and, in turn, can result in the development of obesity and its attendant consequences such as the development of type 2 diabetes.

Let's return to the Y chromosome that results in the formation of a testis which during fetal life produces the male hormones called androgens the major one of which is testosterone. In the fetus this causes the development of the male genitals and the prostate gland. During puberty androgens circulate in the bloodstream and influence the male reproductive organs but also many other tissues such as skin, muscle, bone, hair, voice and the brain.

New information indicates that the sex determining genes on the Y chromosome are expressed the male brain before the testis is formed and therefore before testosterone is secreted by the fetal testis. This action in the brain indicates suggests that traits or behaviour may be influenced without the action of testosterone.

The journey through puberty can be hazardous for many with the challenges of peer pressure causing conflict with parental values on such issues as smoking and alcohol with the ever present exposure to drugs of varying types. All of these external influences are bearing upon an individual who is experiencing the effects of his pubertal surge in testosterone production with its well established actions on growth, muscular strength, sexual development and behaviour. The behavioural patterns of dealing with sexuality, the risk of pregnancy and the possibility of sexually transmitted disease, as well as the increasing level of responsibility in decision making required in a variety of life events such as scholastic pathways and future careers, all can lead to significant levels of stress in individuals that do not have support systems at home and at school. All of these issues act on the genetic template and the same external influences, exerted on individuals with different genomes, can have profoundly different outcomes.

What of the issues confronting adult men that should be represented in a men's health policy? It is clear that the advances in medical care have extended the lifespan of both men and women but the 7 year gap in the 1970s has narrowed slightly to about 5 years in 2001. Setting aside the health issues related to the reproductive organs, there is a greater propensity for men to have higher rates of all forms of cardiovascular disease and many forms of cancer.

The reasons remain unclear but clearly may be related to the male genome and of course to the levels of androgens and estrogens that differentiate men from women. The issues that remain unanswered to me relate to the balance, on one hand between the biological determinants of male behaviour such as their genetic status and, on the other hand, the psycho-social and environmental determinants.

Cardiovascular disease, including stroke and hypertension, linked to obesity and diabetes, together with cancer, are the largest causes of male mortality representing about 66%. However, the causes of mortality in men under 34 years of age show that accidents accounted for 35.5% and suicide for 30.6 %.

These differences clearly require different male health policies. The high rate of suicide brings into prominence the important issues of depression and mental illness and need to inform policy development that not only deals with the immediacy of those issues but must address the developmental and societal processes that make men more vulnerable to these risks but again please don't ignore the genetic template of these men.

Today, the epidemic of obesity is causing great concern in many countries across the globe. In Australia 20% of men were obese and another 44% were overweight in a randomly sampled population of 6000 men in Australia aged from 40 to 70 plus years as part of the Men in Australia Telephone Survey or MATeS study. This is a major cause for concern because of the links to diabetes and cardiovascular disease. A recent report from the Office of the Chief scientist in the UK projected that the rates of obesity in the UK by 2050 would be 60% in men, 45% in women and 30% of children and this would add £50 billion annually to their health budget.

The other major issue that affects the ageing male and female population today is that of dementia including Alzheimer's disease with figures suggesting that by 85 years there is a 1 in 4 chance of developing dementia. The answers in this area are not yet available but the continuation of mental stimulation is emerging as a potential way of delaying or preventing the onset. Any policy developed today should ensure that these issues are addressed.

I want to now turn briefly to the issues of andrology, the male counterpart to gynaecology, that impact on the adult and older male population. In the younger population, testicular cancer, male infertility and sexually transmitted disease are major issues.

The link between undescended testes, and both testicular cancer and male infertility, make it essential that a policy should identify ways in which continuity of care, education and transfer of information are managed effectively between paediatricians and general practitioners. An electronic health record would solve many issues of communication.

In older men, the prevalence data in andrology indicate a significant burden of disease particularly in older men, with 38% of men having some form of prostate disease by age 70 years and the 2006 figures indicating that about 18,500 all men were diagnosed as having prostate cancer. Note that 50% of the 6000 men in the MATeS study over 40 years had had a DRE and/or a PSA test, increasing to 70% in the men over 70 years. These data clearly indicate that men are willing to consider testing for prostate cancer, even though not perfect, as part of a proactive program.

With an extended healthy lifespan, men continue to be sexually active with 37% of men reporting sexual activity beyond 70 years. In this context it is important to note that approximately 70% of men at that age have problems of erectile dysfunction and figures reported for androgen deficiency in the over 70 age group range from 6% to 31%.

These conditions also have significant links to non-reproductive health. A study, which followed men after their first episode of moderate impotence, found that within 12 months, 2% of men had a stroke or heart attack and within 5 years this rose to

11%. These means inquiry about ED is a window into a man's cardiovascular system. Given that the MATeS study identified that 20% of the 6000 men over 40 years experienced moderate to severe impotence and that a study ED in indigenous men was about 40%, this is a problem of very significant magnitude. Further despite 80% of the 6000 men interviewed in the Mates study reporting that they would be very concerned if they had erectile dysfunction, only 30% of men with ED had spoken to a doctor. Thus, a vital sign of cardiovascular disease and diabetes is lost by this reticence to discuss issues of sexuality. Let's also not forget the psychological consequences of impotence of loss of self-esteem, depression and the possibility of alcohol and drug abuse and ensuing domestic violence. These are likely to be augmented in indigenous communities due to these matters being part of men's business. In fact, we need to make major in roads into the improvement of indigenous men's health as a special initiative.

While androgen deficiency clearly affects libido, its links to non-reproductive health issues are now emerging. Diminished quality of life and poorly definable issues such as tiredness, mood swings and hot flushes often occur.

Fat increases the conversion of testosterone to the female hormone estrogens and body builders recognise that testosterone helps build muscles and reduce fat. Androgen deficiency in obese men can predict the development of insulin resistance and the likelihood of the development of type 2 diabetes. Further about 40% of obese late onset diabetics, testosterone levels were low and testosterone treatment improved sensitivity to insulin and diabetic control and decreased visceral fat and lowered cholesterol levels.

Finally, testosterone is critical in the development of strong bones and androgen deficiency in older men is a cause of osteoporosis, resulting in fractures about 10 years later than in postmenopausal women. The MATeS study identified that only 1.5% of the 6000 men over 40 years were on androgen treatment, indicating that many cases of androgen deficiency are missed since the frequency of androgen deficiency ranges from 6-31% of men over 70 years.

The MATeS study provided our first national cross-sectional, self-reported health assessment of men over 40 years onward. It is critical now critical that a longitudinal study of men, commencing at a younger age that includes a clinical assessment of selected cohorts, is initiated to provide data that defines how identified risk factors both biological and psycho-social impact on health outcomes later in life.

I hope that this traverse across a wide range of fields that impact on male health enabled you to understand why a policy designed to improve male health requires careful consideration of the factors operate from life in the womb right through to the elderly. Such a policy would provide the basis to enhance the health of men and to enable them to engage fully and beneficially in society.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-032

OUTCOME 1: Population Health

Topic: OBESITY

Written Question on Notice

Senator Ryan asked:

Has the Department undertaken or commissioned any research on whether higher rates of obesity surgery would be cost beneficial to the public health system, and if so, what were the findings?

Answer:

The Department has not undertaken or commissioned any research on whether higher rates of obesity surgery would be cost beneficial to the public health system. However it is aware of research in this area. Attachment A provides a summary of published Cochrane and non-Cochrane Systematic reviews.

The attachment is accessible at the following link:
http://www.health.qld.gov.au/ph/documents/caphs/32117.pdf

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-149

OUTCOME 1: Population Health

Topic: OBESITY

Hansard Page: CA 113

Senator Adams asked:

What research has been done on treating obesity as an eating disorder rather than as a lifestyle program?

Answer:

The Department has not undertaken any research on treating obesity as an eating disorder however, there is a considerable range of research into obesity in the public domain which may include this topic.

The National Health and Medical Research Council (NHMRC), an independent statutory agency within the Health and Ageing portfolio, does fund research into various aspects of obesity ($22.9 million in 2008). The NHMRC has advised that there does not appear to be any grants specifically investigating the treatment of obesity as an eating disorder.

The Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) defines eating disorders as anorexia nervosa, bulimia nervosa and eating disorders not otherwise specified. Obesity is not considered a mental disorder and therefore is not considered by the DSM-IV as an eating disorder.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-029

OUTCOME 1: Population Health

Topic: LAPAROSCOPIC GASTRIC BANDING

Written Question on Notice

Senator Ryan asked:

How many laparoscopic gastric banding and gastric bypass procedures have been performed in public hospitals each year in the last two years in:

a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?
i) How many laparoscopic gastric banding and gastric bypass procedures were performed overall during this period?

Answer:

a) – h) The *National Health Information Agreement* (Section 3.2) requires the department to gain the permission of each state or territory in order to release this information.

i) National totals for laparoscopic gastric banding and gastric bypass procedures:

Procedure description	No. of procedures	
	2006-07	2007-08
Laparoscopic gastric banding	8,193	12,247
Gastric bypass	1,541	1,743

(Source: *Admitted Patient Care National Minimum Data Set*)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-031

OUTCOME 1: Population Health

Topic: CRITERIA FOR LAPAROSCOPIC GASTRIC BANDING

Written Question on Notice

Senator Ryan asked:

Is there a minimum and maximum patient age or any other conditions placed on these (laparoscopic gastric banding and gastric bypass) procedures?

Answer:

The suitability of a candidate for bariatric or weight loss surgery, including laparoscopic gastric banding and gastric bypass surgery is a clinical decision for the surgeon. According to the Obesity Surgery Society of Australia and New Zealand, the following are widely accepted criteria which make a patient suitable for these procedures:

- weight greater than 45kg above the ideal body weight for sex, and height;
- BMI > 40 by itself or >35 if there is an associated obesity illness, such as diabetes or sleep apnoea;
- where reasonable attempts at other weight loss techniques have been unsuccessful;
- age 18-65;
- obesity related health problems;
- no psychiatric or drug dependency problems;
- a capacity to understand the risks and commitment associated with the surgery; and
- pregnancy not anticipated in the first two years following surgery.

The Society notes that there is considerable flexibility in these guidelines and in regard to age, patients as young as 12 have been offered surgery. Sometimes a lower BMI between 30 and 35 is accepted if comorbidities exist.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3&4 June 2009

Question: E09-048

OUTCOME 1: Population Health

Topic: SOLARIUM GUIDELINES

Written Question on Notice

Senator Brown asked:

On the 25 January Standards Australia released a revised Standard for the operation and management of solariums. The Tasmanian Government recently released draft guidelines of the use of Solariums for public comment.

(a) How have the revised Standard released by Standards Australia on the operation and management of solariums been received?

(b) Whilst the new Standard is obviously voluntary, what action has been taken on a national and/or state by state basis to draft and/or amend current legislation to reflect the new Standard?

Answer:

(a) The questions in relation to how the revised Standard has been received in the wider community would be more appropriately directed to Standards Australia.

(b) The Government has worked with the states and territories through ARPANSA's Radiation Health Committee (RHC) to develop nationally uniform regulatory arrangements for solaria that include provisions from the Australian Standard Solaria for Cosmetic Purposes (AS/NZS 2635: 2008). The RHC has recommended, through the established process for developing nationally uniform radiation protection policy, that health ministers agree to adopt these regulatory arrangements into their existing state and territory regulatory frameworks.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3&4 June 2009

Question: E09-049

OUTCOME 1: Population Health

Topic: NEW SOLARIUM GUIDELINES

Written Question on Notice

Senator Brown asked:

Mark Konemann from the Australian Solarium Association says national uniform regulation will make the industry safer – have there been any moves made toward national uniform regulation?

Answer:

The Government has worked with the states and territories through ARPANSA's Radiation Health Committee (RHC) to develop nationally uniform regulatory arrangements for solaria. The RHC has recommended, through the established process for developing nationally uniform radiation protection policy, that health ministers agree to adopt these regulatory arrangements into their existing state and territory regulatory frameworks.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3&4 June 2009

Question: E09-050

OUTCOME 1: Population Health

Topic: SOLARIUM GUIDELINES

Written Question on Notice

Senator Brown asked:

The new Standard includes requirements restricting the use of people under the age of 18, and ensuring all clients complete a skin type assessment test – how are such requirements likely to be monitored and enforced if enshrined in state-based legislation?

Answer:

The Government is working with the states and territories through ARPANSA's Radiation Health Committee (RHC) to develop nationally uniform regulatory arrangements for solaria that include the requirements specified. The RHC has recommended, through the established process for developing nationally uniform radiation protection policy, that health ministers agree to adopt these regulatory arrangements into their existing state and territory regulatory frameworks. Enforcement of these provisions will be undertaken by state and territory regulators in accordance with their existing regulatory frameworks. Some states and territories have already adopted these requirements.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3&4 June 2009

Question: E09-051

OUTCOME 1: Population Health

Topic: NEW SOLARIUM GUIDELINES

Written Question on Notice

Senator Brown asked:

In response to the current Tasmanian consultation period on the draft guidelines the Tasmanian Cancer Council has suggested that solarium use should be banned in Tasmania – do you believe this is realistic and necessary?

Answer:

No. Developing and implementing a nationally consistent regulatory framework was considered by the Radiation Health Committee to be the most appropriate course of action.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-316

OUTCOME 1: Population Health

Topic: HUMAN GENE THERAPY

Written Question on Notice

Senator Heffernan asked:

a) Is there any human gene therapy funded directly or indirectly through the healthcare system in Australia? If so elaborate.
b) What is the cost of such gene therapy per treatment?
c) Where and by whom is that gene therapy conducted in Australia?
d) Are there any Australian patents that apply to such gene therapy? If so, what licenses have been negotiated with the patentees (or their exclusive licensees) and how many of the patentees (or their exclusive licensees) been paid?

Answer:

a) There are no gene therapy products registered for use in Australia under the *Therapeutic Goods Act 1989*. However, the Australian Government funds clinical research for human gene therapy through the National Health and Medical Research Council and other research programs.

b) Expenditure on clinical research for human gene therapy is not available in an aggregated format and its compilation would involve a significant diversion of resources.

c) Information on location of clinical research for human gene therapy and on researchers who conduct such research is not available in an aggregated format and its compilation would involve a significant diversion of resources.

d) This part seeks information about patents and patenting practices, which is matter for IP Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-317

OUTCOME 1: Population Health

Topic: HUMAN GENE TESTING

Written Question on Notice

Senator Heffernan asked:

a) Is there any human gene testing funded directly or indirectly through the healthcare system in Australia? If so, elaborate.
b) What is the cost of each such gene test per test per patient?
c) Where and by whom is that gene testing conducted in Australia?
d) Are there any Australian patents that apply (or that have applied) to such gene testing? If so, what licenses have been negotiated with the patentees (or their exclusive licensees) and how much of the patentees (or their exclusive licensees) been paid?

Answer:

a) There are 16 genetic tests funded directly by the Department of Health and Ageing under the Medical Benefits Schedule (MBS). Further information is available at: http://www.health.gov.au/internet/mbsonline/publishing.nsf/Content/B1597A1010C947C3CA257599000203FB/$File/200905-Cat6.pdf (see Group P7 - Genetics).

   The Australian Government also indirectly contributes to other genetic tests and services which are funded by states and territories through the National Healthcare Agreements (NHA). However, expenditure on genetic testing through NHAs is not identified separately so a specific breakdown cannot be provided.

   Genetic tests may also be funded through private health insurance. Private health insurance is indirectly funded by the Commonwealth Government through the private health insurance rebate. However, expenditure on genetic testing through private health insurance, is not identified separately in the Private Health Insurance Administration Commission data collection, so a specific breakdown cannot be provided.

b) Commonwealth Expenditure on Genetic Testing under the MBS

   2007-08: $20,538,574 (including safety net)
   2008-09: $21,408,455 (projected benefits including safety net)

   Private health insurers may pay benefits for genetic tests as part of hospital treatment or general treatment. Where a person holds a policy covering hospital treatment for a genetic test for which a Medicare benefit is payable the private health insurer will have

to pay at least 25% of the MBS fee, (or the balance payable after the first 75% is paid by Medicare if the charge is less than 100% of the schedule fee).

Private health insurers can choose to pay benefits for genetic testing in respect of general treatment. However, benefits cannot be paid in respect of general treatment where the test is listed on the MBS.

Further information is not available in an aggregated format and its compilation would involve a significant diversion of resources.

c) This part seeks information which is not available in an aggregated format and its compilation would involve a significant diversion of resources.

d) This part seeks information about patents and patenting practices, which is matter for IP Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-318

OUTCOME 1: Population Health

Topic: GENE PATENTS - BIOPHARMACEUTICALS

Written Question on Notice

Senator Heffernan asked:

a) Is there any biopharmaceutical funded directly or indirectly through the healthcare system in Australia? If so, elaborate.
b) What is the cost of each biopharmaceutical per administration per patient?
c) Where and by whom is that biopharmaceutical administered in Australia?
d) Are there any Australian patents that apply (or have applied) to such biopharmaceuticals? If so, what licenses have been negotiated with the patentees (or their exclusive licensees) and how much have the patentees (or their exclusive licensees) been paid?

Answer:

a) Information regarding the direct Commonwealth funding of biopharmaceuticals, including through the Pharmaceutical Benefits Scheme (PBS), is not available in an aggregated format and its compilation would involve a significant diversion of resources.

   The Australian Government also indirectly contributes to other biopharmaceuticals, which are funded by states and territories through the National Healthcare Agreements (NHA). However, expenditure on biopharmaceuticals through NHAs is not identified separately so a specific breakdown cannot be provided.

   Biopharmaceuticals may also be funded through private health insurance. Private health insurance is indirectly funded by the Australian Government through the private health insurance rebate. However, expenditure on biopharmaceuticals through private health insurance, is not identified separately in the Private Health Insurance Administration Commission data collection, so a specific breakdown cannot be provided.

   If a pharmaceutical forms part of general treatment and there is a 'supply' of that drug to an individual on the PBS, a private health insurance benefit cannot be payable. However, if there is no 'supply' of that drug a health insurer may choose whether or not to pay a benefit.

In many cases private health insurers choose to pay a limited general treatment benefit for pharmaceuticals that are not listed on the PBS and do not pay anything for pharmaceuticals that are listed on the PBS, regardless of whether they are 'supplied' on the PBS.

If a pharmaceutical which is supplied on the PBS is covered in a policy for hospital treatment or hospital-substitute treatment a benefit may be payable in respect of the co-payment.

b) Refer to part a).

c) This part seeks information which is not available in an aggregated format and its compilation would involve a significant diversion of resources.

d) This part seeks information about patents and patenting practices, which is matter for IP Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-331

OUTCOME: 1 Population Health

Topic: SOLARIUM GUIDELINES

Hansard Page: CA 15

Senator Brown asked:

Please provide National Guidelines on the use of Solariums

Answer:

The Government has worked with the states and territories through the Radiation Health Committee (RHC) to develop nationally uniform regulatory arrangements for solaria and proposes to include these in the National Directory for Radiation Protection (NDRP). The regulatory arrangements that the RHC propose to be included in the NDRP are as follows:

5.4 Adoption of national regulatory elements for control of specified practices

In a case where no Code of Practice or Standard applies to a practice specified in this Section, the provisions applying to that practice must be adopted by Authorities within their regulatory frameworks.

5.4.1 Solaria

The Responsible Person in relation to the operation of a solarium used for cosmetic purposes must ensure that:

(a) No individual under the age of 18 is permitted to be exposed in a tanning unit that is under the control of the Responsible Person.

(b) Any operator of a tanning unit has completed approved training in the following:

(i) Safe use and operation of the tanning unit;

(ii) Use of exposure schedules;

(iii) The requirements of Australian Standard AS/NZS 2635:2008 and its practical implementation;

(iv) Determination of skin photo types (using the Fitzpatrick classification system) and exposure times;

(v) Screening for potentially exposure limiting conditions;

(vi) Emergency procedures in case of over-exposure to UV light;

(vii) Types and wavelength of UV light, and health risks;

(viii) Procedures for sanitizing protective eyewear and tanning equipment.

(c) An assessment of skin type is conducted by a trained operator for every client before exposure in a tanning unit, and that individuals with skin type 1 are not permitted to be exposed in a tanning unit.

(d) Only a trained operator determines and controls an exposure session.

(e) Exposure of any client to ultraviolet radiation in a solarium is subject to supervision by a trained operator at all times.

(f) Prior to the commencement of a course of tanning of one or more exposure sessions in a tanning unit, a consent form as set out in Table A is handed to the client, and that:

(i) The client signs and dates the form;

(ii) The client returns the signed and dated form prior to commencement of the first exposure session in the establishment;

(iii) The original signed and dated form is filed in the records of the establishment for a period of not less than 2 years;

(iv) A copy of the signed and dated form is handed to the client.

(g) Any exposure session does not exceed 0.9 MED, and that any repeat exposure session takes place no sooner than 48 hours after the previous exposure session.

(h) Protective eyewear is worn by every user of a tanning unit during any period for which the tanning unit is operative.

(i) Warning notices of an appropriate size are placed within immediate view of every client entering a solarium, and in each tanning unit cubicle. The warning notice must include the following information:

- Tanning units emit ultraviolet radiation;
- Exposure to ultraviolet radiation contributes to skin cancer and skin ageing;
- Repeated exposure further increases risk;
- People with fair skin who burn easily will not be permitted to use a tanning unit;
- Further intentional exposure to sunlight or a tanning unit must be avoided for the next 48 hours;
- Protective eyewear must be worn at all times while undergoing tanning unit exposure;
- No person under the age of 18 years is permitted to use a tanning unit."

TABLE A

CONSENT FORM FOR CLIENTS OF SOLARIA

CLIENT CONSENT FORM

Please read carefully the following information:

1. Exposure to ultraviolet radiation such as from a tanning unit contributes to skin cancer and the skin ageing process.
2. People with fair skin who are unable to tan must not use a tanning unit.
3. Intentional tanning unit exposure should be avoided for 48 hours before and after sunlight or tanning unit exposure.
4. Protective eyewear must be worn at all times while undergoing tanning unit exposure. You must not read while the tanning unit is in operation.
5. There is additional risk, and sun-tanning unit exposure is not recommended if you -
   (a) have ever been treated for solar keratoses or skin cancer;
   (b) have a large number of moles, freckles and /or naevi;
   (c) have a history of frequent childhood sunburn;
   (d) burn easily; or
   (e) have ever suffered from an abnormal reaction, or allergy, to light.
6. There may be further risk if you are pregnant, taking certain medications by mouth or applying medications or certain cosmetics to the skin.

If there is any doubt in your mind in relation to any of the particulars described in Items 2, 5 and 6 above, consult your doctor before undergoing any ultraviolet exposure.

I, ……., am aged 18 years or over, acknowledge that the trained operator has made an assessment of my skin type, and have carefully read and fully understand the above information and choose to undergo ultraviolet exposure in this establishment.

Client Signature:…….Date: ……

Name of establishment: .....…….....

Schedule 2 – Categories of Non-ionizing Radiation

(Refer sections 2.3(j) and 2.6(g))

Schedule 2, which was blank in Edition 1 of NDRP, is amended to include the following:

The following non-ionizing radiation apparatus that produce harmful non-ionizing radiation when energised are specified as requiring regulatory control.

(1) A tanning unit used for cosmetic purposes within a solarium;

Glossary

The Glossary is amended to add the following definitions

CIE means Commission Internationale de l'Eclairage

Erythemally Effective Dose means the dose obtained by weighting the spectral distribution of UV radiation incident on the subject with the erythemal effectiveness set by the CIE across the UV radiation wavelength range (280 to 400 nm) and then integrating to obtain the total dose in $J.m^{-2}$.

Exposure Session means a session of exposure to UV radiation in a solarium, and where the total exposure does not exceed 0.9 MED.

MED – Minimum Erythemal Dose means the minimum dose of UV radiation required to produce erythema (sunburn) in the skin. For skin photo type 1, MED is 2 SED (200 $J.m^{-2}$). For skin photo type 2, MED is 2.5 SED (250 $J.m^{-2}$). For skin photo type 3, MED is 3 SED (300 $J.m^{-2}$). For skin photo type 4, MED is 4.5 SED (450 $J.m^{-2}$). For skin photo type 5, MED is 6 SED (600 $J.m^{-2}$). For skin photo type 6, MED is 10 SED (1000 $J.m^{-2}$).

Responsible Person is as defined in the National Directory for Radiation Protection

SED – Standard Erythemal Dose means 100 $J.m^{-2}$ of erythemally effective dose. For example, an erythemally effective dose of 200 $J.m^{-2}$ is 2.0 SEDs which is sufficient to cause mild reddening or erythema in people with skin type 1 (fair skin).

Skin Photo Type 1 means skin which always burns and never tans (pale white skin).

Skin Photo Type 2 means skin which always burns easily and tans minimally (white skin).

Skin Photo Type 3 means skin which burns moderately and tans uniformly (light brown skin).

Skin Photo Type 4 means skin which burns minimally and always tans well (moderate brown skin).

Skin Photo Type 5 means skin which rarely burns and tans profusely (dark brown skin).

Skin Photo Type 6 means skin which never burns (deeply pigmented dark brown to black skin).

Solarium means any commercial establishment containing one or more tanning units.

Supervision means being on the premises to ensure that all pre-exposure requirements are fulfilled and to ensure that the exposure session is terminated at the appropriate time.

Tanning unit means an electrically powered appliance or installation intended to produce tanning of the human skin by utilizing ultraviolet radiation

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-248

OUTCOME 1: Population Health

Topic: INDIGENOUS TOBACCO CONTROL INITIATIVE (ITCI)

Written Question on Notice

Senator Adams asked:

a) The Indigenous Tobacco Control Initiative (ITCI) was launched in March 2008. Do you have any feedback after over a year of the program?
b) There has been a specific focus on young people who smoke. What are you specifically doing differently to target young people?
c) Will you be reporting on the success of this initiative, both in the long term and short term?
d) If so, what are the planned reporting periods?

Answer:

a) Four community-based smoking cessation projects have been implemented under ITCI in 2008-09. These four projects are: the Miwatj Tobacco Control Project in North East Arnhem Land in the Northern Territory; the Northern Rivers Smoking Intervention Research Project in rural New South Wales; and two comprehensive community based smoking cessation services to be run through the Bila Muuji Regional Aboriginal Health Service, Western New South Wales and the North Coast Aboriginal Corporation for Community Health based in Maroochydore, Queensland.

   Funding has also been provided to enhance the Top End Tobacco Project in the NT, which aims to reduce tobacco smoking in three remote Aboriginal communities and several homelands and to enhance the Maari Ma Smoking Cessation Project, in rural NSW, which offers 12-week individualised treatment interventions in seven Aboriginal communities across the rural NSW region.

   The funding arrangements for each of these projects include evaluation requirements which will be considered in managing the initiative and its outcomes.

   A $10.7 million Open Funding Round for projects under ITCI was advertised in the national and Indigenous press in early July 2009.

b) Youth-focused activities undertaken under the ITCI to date include working with Indigenous schools to support school curriculum aimed at preventing the uptake of smoking, and providing brief interventions to parents with young children.

c) All projects funded include an evaluation requirement. Project evaluations will build the evidence base to inform and help the tobacco control element of the Council of Australian Government (COAG) Indigenous Health National Partnership as it is rolled out from 2009-10.

d) Reporting periods are different for each project funded under the initiative. Each project is required to provide at least an annual report on progress.

Progress will be discussed with the Technical Reference Group of experts advising on the development and roll-out of the COAG tobacco control measures. Progress on the initiative will also be reported in the normal way through the Department's annual report.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-247

OUTCOME 1: Population Health

Topic: INDIGENOUS HEALTH PROMOTION

Written Question on Notice

Senator Adams asked:

a) In relation to Indigenous targets health promotion, do you have a planned long term reporting period as to how successful these initiatives have been?
b) You mentioned during the February 09 estimates that there are short term findings, do you have these available?
c) What has been the success, so far of these initiatives?

Answer:

a) The Government has set long-term Indigenous health related performance benchmarks, progress measures and outputs in the National Healthcare Agreement (for example, smoking prevalence) and the National Partnership Agreement on Closing the Gap in Indigenous Health (for example, improved sexual health outcomes and reduced uptake of alcohol, tobacco and illicit drugs). These indicators and outcomes will be used to assess the effectiveness of a range of Indigenous health programs and activities both at the Commonwealth and State/Territory level.

   Most of the Department's programs in Indigenous health promotion have only recently commenced or are currently under development, and as such have not yet been the subject of evaluation.

b and c)

There are a number of programs and projects funded by the Department for which information on their short-term benefit is available, including:

- *VIBE Australia* – the Government supports VIBE Australia to develop, produce and disseminate quality health and lifestyle promotion materials targeting Indigenous Australians, including Vibe 3 on 3 Basketball competitions. A review in 2006 provided positive results, including that the basketball competitions helped health messages reach young people and the wider community and helped bring the community together.

- *Sniffing and the brain flip chart* – the Department funded the development and distribution of a flipchart for health professionals, community workers, drug and alcohol counsellors and similar stakeholders to use when talking to a range of audiences about the effects of sniffing on the body. A review conducted in 2006 found that the *Sniffing and the brain flipchart* provides stakeholders with a valuable tool and information relating to petrol and inhalant misuse and it has the ability to resonate with a diverse audience at an individual, group or community level.
- *Retailers' Responsible Sale of Solvents* – provides support for a number of organisations to assist retailers by providing training and education and assistance in developing a coordinated response to customers whom they suspect of buying solvents for the purpose of sniffing in the Darwin and Palmerston areas. An evaluation in 2007 found the rollout of the retailers' kit raised awareness amongst retailers, forged links with stakeholders in the community to reduce the supply, demand and harm of the misuse of solvents, and promoted more careful storage of solvents.
- *Substance Misuse Community Resilience Project* (South Australia) – is a peer support network of Aboriginal grandparents ('the Grannies Group') who advocate on behalf of issues affecting their children, grandchildren and their community by creating awareness of drug issues and who offer support and encouragement for a community approach to resolving problems. An evaluation in 2008 found that Indigenous elders have provided a positive impact on young people by highlighting the tragic affects of substance misuse on themselves, their families and their community.

In general, these initial results indicate that Indigenous ownership of projects, from inception to completion, has a greater impact on the project being successful and accepted by the wider Indigenous community.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-013

OUTCOME 1: Population Health

Topic: REGULATORY CONTROLS WITH COSMETIC SURGERY

Written Question on Notice

Senator Ryan asked:

a) What regulatory controls exist over those performing cosmetic surgery?
b) What level of education, training and/or professional accreditation is required for those performing cosmetic surgery?
c) What, if any, level of ongoing training is required to continue to practice in this field?
d) How are individual practitioners and clinics registered?
e) How does this regulatory regime compare to general practitioners and to members of the College of Surgeons and College of Physicians?

Answer:

a) Regulation of cosmetic surgery is a matter for states and territories. In July 2008 the Australian Health Ministers' Conference (AHMC) referred the matter of investigating a national approach to regulation of the cosmetic surgery industry to the Australian Health Ministers' Advisory Council (AHMAC). An inter-jurisdictional cosmetic surgery working group has been established and will report back to AHMC at a later date.

b) Cosmetic surgery is a very broad term for a large number of procedures designed to alter appearance. In a narrower sense, cosmetic surgery is mostly performed by medical practitioners; however procedures can also undertaken by dentists. There is no single vocational pathway for medical practitioners who perform cosmetic surgery. As such, there is a lack of clarity regarding qualifications of practitioners. Other cosmetic procedures may be performed by nurses and beauty therapists.

c) Medical practitioners who perform cosmetic surgery procedures must be registered with the relevant state or territory medical board. Registration includes the requirement for ongoing continuing medical education. The Australian College of Cosmetic Surgery maintains training programs for medical practitioners. It should be noted that the College has not been approved by the Australian Medical Council as a provider of cosmetic surgery training and there is no requirement for a practitioner to undergo this training in order to practice as a cosmetic surgeon.

d) Medical Practitioners are currently registered through individual state and territory registration boards and must maintain their registration in order to practice. The National Registration and Accreditation Scheme for health practitioners will commence on 1 July 2010. Under the Scheme, all medical practitioners, including cosmetic surgeons and plastic surgeons, will be subject to the nationally consistent registration requirements. There is no requirement for clinics to be registered, although there may be applicable state or territory laws regulating clinics.

e) Surgeons and physicians must also maintain registration through state and territory registration boards and will also be subject to the requirements of the National Registration and Accreditation Scheme from 1 July 2010. A significant number of cosmetic surgery practitioners are Fellows of a medical college or have undertaken training within a college.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-144

OUTCOME 1: Population Health

Topic: NATIONAL PARTNERSHIP AGREEMENT ON PREVENTIVE HEALTH

Hansard Page: CA 92

Senator Barnett asked:

a) Provide what you have within your possession that indicates the level of resources in terms of that currently committed by the states and territories to this (anti obesity, tobacco and alcohol) objective?

b) More specifically (can you provide) the further and better particulars of the projects to be funded by the $872.1 million?

Answer:

a) *Public health expenditure in Australia 2006-07* (AIHW) reports public health expenditure for each jurisdiction, including health promotion, but this data is not disaggregated to identify focal areas such as obesity, tobacco and alcohol. The Commonwealth does not hold other data on state and territory expenditures on obesity, tobacco and alcohol.

Source
Australian Institute of Health and Welfare 2008. *Public health expenditure in Australia, 2006-07*. Health and Welfare expenditure series no. 34. Cat. No. HWE 41. Canberra: AIHW

b) In accordance with the National Partnership Agreement on Preventive Health, a National Implementation Plan has been developed with the States and Territories. The National Plan is currently being considered by Health Ministers from all jurisdictions and once agreed will be made available on the Ministerial Council for Federal Financial Relation's website (www.federalfinancialrelations.gov.au).

The various initiatives funded through the Partnership are detailed below.

Healthy Communities ($72 million from 2009–10 to 2012–2013)

- This initiative will support a targeted, progressive roll out of community-based healthy lifestyle programs which will facilitate increased access by disadvantaged groups and those not in the workforce to physical activity, healthy eating and healthy weight activities. The Commonwealth will administer funding to local government organisations, provide a national quality assurance framework, the accreditation/registration of programs and service providers, and a web based information portal.

Healthy Children ($325.5 million from 2011–12 to 2014–15)

- State and territory governments will implement a range of interventions for children 0 to 16 years of age to increase physical activity and improve nutrition through child care centres, pre-schools, schools and within families. Programs are likely to vary across jurisdictions, and may include intensive programs to support at-risk children and their families in achieving healthy weight and healthy eating and exercise programs in children's settings.

Healthy Workers ($294.4 million from 2011–12 to 2014-15)

- This initiative provides funding to support implementation of healthy lifestyle programs in workplaces targeting overweight and obesity, physical inactivity, poor diet, smoking and the excessive consumption of alcohol (including binge drinking). The states and territories will facilitate the implementation of programs in workplaces and the Commonwealth will support these programs with national-level soft infrastructure including developing a national charter, voluntary competitive benchmarking, nationally agreed standards for workplace prevention programs, and national awards for excellence in workplace health programs.

Industry Partnership ($1 million from 2009–10 to 2012–2013)

- This initiative will develop and support partnerships between Governments and various relevant industry sectors to encourage changes in their policies and practices so they are consistent with the Government's healthy living agenda. The partnerships will initially focus on the food industry, and may extend to the fitness and weight loss sectors following the establishment of the quality assurance element of the Healthy Communities initiative. The Commonwealth will manage the implementation of this initiative in consultation with the states and territories.

Social Marketing ($120 million from 2009–10 to 2012–2013)

<u>MeasureUp ($59 million)</u>

- This initiative provides supplementary funding for MeasureUp, in order to extend its duration by three years and expand its reach to high-risk groups. Activities under the campaign aim to raise awareness of healthy lifestyle choices, focusing on the importance of physical activity and nutrition, as well as the link between lifestyle behaviours and the risk of some chronic disease. The Commonwealth will manage and coordinate a national integrated program of social marketing activity ($41 million), whilst the states and territories will deliver a program of activities at the local level that reinforce and extend the national campaign messages ($18 million).

<u>Tobacco ($61 million)</u>

- This initiative provides funding for national level social marketing activities focusing on smoking in order to lay the foundations for healthy behaviours in the daily lives of Australians and address the rising prevalence of smoking related chronic diseases. The Commonwealth will administer these funds in consultation with the states and territories, and the states and territories have committed to fund local level activities to support the national activities.

Enabling Infrastructure ($59.2 million from 2009–10 to 2012–13)

National Health Risk Survey ($15 million)

- The National Health Risk Survey (HRS) will collect essential data on prevalence of chronic disease risk factors in the Australian population through a series of surveys covering all jurisdictions. Funding for an initial HRS has been provided through the National Nutrition and Physical Activity Survey Program - this survey is expected to be conducted in 2010-11 and will focus on adults. A second HRS will be conducted in 2012-13 and will focus on children.

Enhanced State and Territory Surveillance ($10 million)

- This initiative provides funding for the implementation of a complementary system of more frequent health, nutrition and physical activity monitoring surveys. The states and territories will collect and report on the agreed performance indicators and implement surveillance systems using the nationally agreed methodology.

Australian National Preventive Health Agency ($17.6 million) and research fund ($13 million)

- The Australian National Preventive Health Agency will be established to provide evidence-based policy advice to Ministers, manage national level social marketing activities targeting obesity and tobacco, administer the preventive health research fund, and oversee the workforce audit and strategy. The Commonwealth has responsibility for these programs and will work closely with the states and territories to ensure effective implementation.

Workforce Audit and Strategy ($0.5 million)

- This initiative will identify and quantify the workforce required to deliver the settings-ased initiatives funded through the prevention NP (Healthy Workers, Healthy Children and Healthy Communities) and propose options to ensure there is sufficient capacity within the sector to support the roll out activities and programs. The Commonwealth will administer the funds for this initiative.

National Eating Disorders Collaboration ($3 million)

- The National Eating Disorders Collaboration (the Collaboration) will facilitate the implementation of a nationally consistent and comprehensive approach to promotion and prevention, early intervention and management of eating disorders. The Collaboration will bring together experts in the field of research, education, health promotion, public health and mental health, as well as the media, to progress a coordinated national approach to eating disorders and provide information to adolescents, schools, health providers and the media. The Commonwealth will administer the funds for this initiative.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June, 2009

Question: E09-329

OUTCOME 1: Population Health

Topic: ALCOHOL RESOURCES

Hansard Page: CA 101

Senator Adams asked:

What is the distribution of promotional resources into rural and remote areas?

Answer:

The Department produces promotional resources and information materials relating to the concept of a standard drink and safe drinking levels. These include posters, brochures, standard drink measuring glasses, water bottles and t-shirts.

These resources are available for order from all parts of Australia, including rural and remote areas, free of charge via www.alcohol.gov.au or by calling the National Mailing and Marketing (NMM) warehouse on 1800 020 013.

The Department is currently updating these resources following the finalisation by the National Health and Medical Research Council of the 2009 Australian Guidelines to Reduce Health Risks from Drinking Alcohol.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-046

OUTCOME 1: Population Health

Topic: METHICILLIN-RESISTANT *STAPHYLOCOCCUS AUREUS* (MRSA) INFECTION

Written Question on Notice

Senator Ryan asked:

How many MRSA infections have been reported or recorded each year for the past two years in:

a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?
i) How many MRSA-related deaths have occurred, by state/territory, over the same period?

Answer:

a – i)

MRSA Infections

A Methicillin-resistant *Staphylococcus aureus* (MRSA) infection can occur in any location in the community and may or may not cause serious disease. There is no information source at this stage which provides data on all MRSA infections.

The ICD-10-AM classification system used to record information on admissions to hospitals (for the National Hospital Morbidity Database) is a potential source of information on MRSA infections in people admitted to hospital. This includes people admitted to hospital with community-acquired MRSA as well as people who acquired an MRSA infection in hospital. However, issues with the quality of this data are still under consideration and the AIHW is currently unable to provide reliable jurisdictional breakdowns for MRSA infections treated in hospital.

Under the performance reporting requirements for the National Healthcare Agreement, work is underway to provide jurisdictional reporting of the most severe type of MRSA infection, MRSA bacteraemia (where the infection enters the blood stream). The Australian Commission on Safety and Quality in Healthcare has been leading work to clarify the definitions, and is establishing a collection based on hospital infection surveillance results.

Consideration is also being given to the possibility of refining the ICD-10-AM codes to specifically identify MRSA bacteraemia in admitted patients. This would allow the AIHW to collect MRSA bacteraemia information in the National Hospital Morbidity Database in the future.

MRSA Deaths

A comprehensive picture of MRSA-related deaths relies on ICD-10 classification coding. At this stage it has not been possible to extract this information from the mortality database. However, work is proceeding within the AIHW, including consideration of the quality of the data, to allow reporting of this cause of death.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-143

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH

Hansard Page: CA 88

Senator Humphries asked:

I assume it would be a medium- to long term goal of government to increase prevention and decrease spending on treatment as a proportion of total outlays. Do we have measures that we can look to actually measure the extent to which we do that?

Answer:

Health Expenditure Australia 2006-07, published by the Australian Institute of Health and Welfare presents the latest available data on health expenditure. I refer you to that publication.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-145

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH TASKFORCE

Hansard Page: CA92-93

Senator Barnett asked:

a) Could you take on notice and advise where, and the details of those (Preventative Health Taskforce consultations) – where and when?
b) Secondly, in terms of reports or consultancies undertaken by the Taskforce, could you, again, provide details of those:
   i) the nature of those;
   ii) the terms of reference for those;
   iii) the date of those;
   iv) the cost of those;
   v) the consultant undertaking those; and
   vi) the time taken to prepare the report and then provide it?
c) And the total cost of the Taskforce to date and expected total cost?

Answer:

a) Consultations

The Preventative Health Taskforce undertook 40 consultations, as follows:

Date	**Consultation**	**Location**
22 October 2008	General Consultation (morning)	Hobart
22 October 2008	General Consultation (afternoon)	Hobart
23 October 2008	General Consultation (morning)	Launceston
23 October 2008	General Consultation (afternoon)	Launceston
31 October 2008	General Consultation	Darwin
31 October 2008	Northern Territory Government	Darwin
31 October 2008	Australian General Practice Network Forum	Darwin
4 November 2008	General Consultation	Alice Springs
7 November 2008	General Consultation	Dubbo

Date	Consultation	Location
17 November 2008	General Consultation	Canberra
17 November 2008	Thematic Roundtable: Prevention and Primary Care, including in remote and rural settings.	Canberra
19 November 2008	Thematic Roundtable: Targets, Strategies, Evidence and Evaluation	Canberra
19 November 2008	Australian Capital Territory Government	Canberra
24 November 2008	General Consultation	Brisbane
24 November 2008	Queensland Government	Brisbane
24 November 2008	Thematic Roundtable: Reshaping Demand and Supply in Food	Sydney
25 November 2008	General Consultation	Cairns
25 November 2008	Indigenous Consultation	Cairns
25 November 2008	General Consultation	Sydney
26 November 2008	General Consultation	Sydney
26 November 2008	NSW Government	Sydney
15 December 2008	Thematic Roundtable: Recreation, Fitness and Weight Loss	Melbourne
15 December 2008	Thematic Roundtable: The Built Environment	Melbourne
29 January 2009	General Consultation	Adelaide
29 January 2009	South Australian Government	Adelaide
29 January 2009	Thematic Roundtable: Reshaping the Culture of Drinking	Sydney
29 January 2009	Thematic Roundtable: Private Health Insurance and Prevention	Sydney
29 January 2009	Thematic Roundtable: Medicines and Prevention	Sydney
30 January 2009	General Consultation	Mount Gambier
3 February 2009	National Indigenous Health Equality Council	Melbourne
5 February 2009	General Consultation	Perth
5 February 2009	Western Australian Government	Perth
5 February 2009	Indigenous Consultation	Perth
6 February 2009	General Consultation	Kalgoorlie
10 February 2009	General Consultation	Melbourne
10 February 2009	Thematic Roundtable: Healthy Workplaces	Melbourne
11 February 2009	General Consultation	Melbourne
13 February 2009	General Consultation	Wodonga
3 March 2009	Independent Sports Panel	Melbourne
18 March 2009	Victorian Government	Melbourne

b) Reports or consultancies
The Taskforce commissioned eight papers and two pieces of writing to assist with the drafting of the National Preventative Health Strategy.

i and iii – vi) The details of the commissioned reports and writings, including the nature, date, cost, consultant and time taken are provided in the tables below.

ii) Terms of Reference for the commissioned reports are available at Attachments A – G.

Commissioned Papers

Consultant	Title of commissioned paper	Author(s)	Terms of Reference	Time taken (approximate estimate)	Paper finalised	Value ($)
S. Friel	*Health equity in Australia: A policy framework based on action on the social determinants of obesity, alcohol and tobacco.*	S. Friel	Attachment A	24 days	26/03/2009	$17,714.40
M. Harris	*The role of primary health care in the prevention of chronic disease.*	M. Harris	Attachment B	8 days	10/03/2009	$5,905.80
J. Garrard	*Taking action on obesogenic environments: Building a culture of active, connected communities.*	J. Garrard	Attachment C	6 days	10/03/2009	$4,428.60
L. King	*Inappropriate food marketing .*	L. King, B. Kelly, T. Gill, J. Chau and K. Chapman	Attachment D	28 days	23/04/2009	$22,732.60
J. Boffa	*Reducing the harm from alcohol, tobacco and obesity in indigenous communities: Key approaches and actions.*	J. Boffa and E. Tilton with D. Legge and B. Genat	Attachment E	28 days	23/04/2009	$17,328.00
T.Chikritzhs	*The impact of the Prevention Task Force target reductions for risky/high risk drinking on national morbidity and mortality, 2007-2020.*	T.Chikritzhs	Verbal request	28 days	1/05/2009	Nil
D. Holman	*Deaths and premature loss of life caused by overweight and obesity in Australia in 2011-2050: Benefits from different intervention scenarios.*	D. Holman and V. Gray	Verbal request	56 days	1/02/2009	Nil
S. Hurley	*Predicted impact of proposed tobacco control strategies .*	S. Hurley, M. Spittal, M. Scollo, S. Durkin and M.Wakefield	Verbal request	28 days	1/03/2009	Nil

Commissioned writing for the Strategy

Consultant	Details of paper	Author(s)	Terms of Reference	Time taken (approximate estimate)	Paper finalised	Value ($)
R. Kent	*Building infrastructure that supports and sustains action*	R. Kent	Attachment F	10 days	30/04/2009	$7,500.00
S. Goldfeld	*Maternal and Child health*	S. Goldfeld, F Oberklaid	Attachment G	14 days	14/05/2009	$3,000.00
					Total ($)	**$10,500.00**

c) The total cost of the Taskforce to date and expected total cost

Expenditure for 2007-08 Financial Year	$42,322.05
Expenditure for 2008-09 Financial Year (not including Departmental costs)	$1,023,675.31
Allocation for 2009-10 Financial Year	$1,000,000.00
Allocation for 2010-11 Financial Year	$1,000,000.00

AMENDED RESPONSE
Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Amended response Question: E09-145

OUTCOME 1: Population Health

Topic: PREVENTATIVE HEALTH TASKFORCE

Hansard Page: CA92-93

Senator Barnett asked:

d) Could you take on notice and advise where, and the details of those (Preventative Health Taskforce consultations) – where and when?
e) Secondly, in terms of reports or consultancies undertaken by the Taskforce, could you, again, provide details of those:
   i) the nature of those;
   ii) the terms of reference for those;
   iii) the date of those;
   iv) the cost of those;
   v) the consultant undertaking those; and
   vi) the time taken to prepare the report and then provide it?
f) And the total cost of the Taskforce to date and expected total cost?

Answer:

d) Consultations

The Preventative Health Taskforce undertook 40 consultations, as follows:

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22 October 2008	General Consultation (morning)	Hobart
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S. Hurley	*Predicted impact of proposed tobacco control strategies .*	S. Hurley, M. Spittal, M. Scollo, S. Durkin and M.Wakefield	Verbal request	28 days	1/03/2009	Nil

Commissioned writing for the Strategy

Consultant	Details of paper	Author(s)	Terms of Reference	Time taken (approximate estimate)	Paper finalised	Value ($)
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S. Goldfeld	*Maternal and Child health*	S. Goldfeld, F Oberklaid	Attachment G	14 days	14/05/2009	$3,000.00
					Total ($)	**$10,500.00**

f) The total cost of the Taskforce to date and expected total cost

Expenditure for 2007-08 Financial Year	$34,328.20
Expenditure for 2008-09 Financial Year as at 12 June 2009 (not including Departmental costs)	$1,023,675.31
Allocation for 2009-10 Financial Year	$1,000,000.00
Allocation for 2010-11 Financial Year	$1,000,000.00

ATTACHMENT A

SOCIAL DETERMINANTS OF HEALTH

Author: Sharon Friel, ANU

Task: **Paper on the social determinants of health equity, in relation to obesity, alcohol and tobacco**

Aim of paper: Identify policy approaches to achieve health equity in Australia based on action on the social determinants of obesity, alcohol and tobacco.

a) Develop an intellectual framework that positions health equity as a central policy goal, to be achieved using a social determinants approach.

b) Using the global WHO Commission on Social Determinants of Health (CSDH) 2008 Final Report *'Closing the gap in generation – Health equity through action on the social determinants of health´* as a point of departure, identify the key social determinants of health in the Australian context and implications of these for preventive health equity – with particular focus on obesity, tobacco and alcohol.

c) Recommend approaches and actions to address key social determinants of inequities in health, especially in relation to obesity, tobacco and alcohol. It is not intended that a fully comprehensive menu of policy approaches be provided, but identification of key policy levers, an illustration of some practical approaches, and mapping of the existing Australian cross-sectoral architecture that could support action on the social determinants of health. An outline of the 'next steps' required to further policy action on the social determinants of health will be provided.

The analysis should take as a departure point the three major areas of action outlined in the CSDH report:

1. Improve daily conditions;
2. Tackle the inequitable distribution of power, money and resources;
3. Measure and understand the problem and assess the impact of action.

The analysis should acknowledge the significance of Indigenous disadvantage in risk factor prevalence, but recognise this is the subject of a separate paper.

ATTACHMENT B

PRIMARY HEALTH CARE

Author: Mark Harris

Task:
Examine the role of primary health care in preventing the onset of chronic disease, with a particular focus on the lifestyle risk factors of obesity, tobacco and alcohol. Identify factors that will encourage clinicians to have a more effective role in preventative health, impediments to primary care in the appropriate exercise of this role and options for the better integration of preventative health practice into the Medicare Schedule and other Government programs. Recommend approaches and actions that could be considered for inclusion in the National Preventative Health Strategy. Without limiting the scope for analysis, the paper should include consideration of:

- cost effective approaches to encouraging systematic checking, monitoring and reporting of chronic disease risks in general practice;*
- cost-effective approaches to providing evidence based interventions for modification of risky lifestyles in the practice and through improved access and funded referral pathways; **
- financial incentives to incorporate the provision of appropriate / targeted screening services, health checks and preventive interventions;
- targeted prevention activities, including targeted recall and follow-up systems for particular at-risk populations, including socially disadvantaged persons, people in rural and remote communities, and Indigenous communities;
- the role and possible rationalisation of risk assessment tools, both relative and absolute, including those for Type 2 diabetes and for CVD and any others relating to the metabolic syndrome; and
- the possible need for a comprehensive framework of risk modification services identifying these by level of intervention, need served, evidence base and quality assurance, and supported by an online directory.

* Having regard to the roles of the GP and the practice nurse, to practice protocols and systems, and to existing MBS-funded health checks;
** Having regard to the roles of the GP, the practice nurse, allied health professionals, programs accredited under the COAG Type 2 Diabetes Initiative, programs provided by NGOs and community health services, and the services of the commercial fitness and weight loss sectors.

ATTACHMENT C

OBESOGENIC ENVIRONMENTS

Author: Jan Garrard

Task:
Identify the core environmental elements which encourage obesogenic behaviours, with particular regard to the built environment and transport and their impact on reducing levels of daily physical activity. Recommend approaches and actions for establishing active, connected communities, moderating these obesogenic influences in the environment and that might be considered for inclusion in the National Preventative Health Strategy. Without limiting the scope of the analysis, the paper should include consideration of:

- other issues which may pose impediments to increased popular use of the urban environment for physical exercise, including issues in personal safety;
- options for integrating increased physical activity into daily commuting for both children and adults, and strategies for fostering the adoption of such measures by state and local governments, private developers, public transport services, schools and education institutions, and workplaces.
- the scope for expanding recreational facilities for physical exercise with broad population reach, and strategies for encouraging popular use of such facilities;
- identify the respective responsibilities and roles of Federal, State and Local Governments and private sector in establishing active and connected communities;
- town planning codes and their impact on urban design for healthy living;
- the effectiveness of such codes in addressing existing urban environments as well as new developments; and
- any issues around voluntarism, industry self-regulation and full regulation in the implementation of such codes.

ATTACHMENT D

INAPPROPRIATE FOOD MARKETING

Author: Lesley King

Task: Develop a research paper that investigates a set of policy options and recommendations regarding inappropriate food marketing in Australia.

Aim of paper: Investigate a set of policy options and recommendations regarding inappropriate food marketing in Australia.

a) Develop a synthesis of recent evidence on:
   - the nature and extent of food marketing to children in Australia;
   - consider this in relation to information on TV viewing patterns and other available information on the times and sites of children's exposure; and
   - the effects of food marketing on children.

b) Develop a synthesis of international regulatory approaches (including industry self regulation) and identify approaches that may be appropriate within the Australian context.

c) Summarise and synthesise existing Australian regulatory approaches.

d) Identify the implications of the evidence described above within the Australian context and describe a set of policy options that considers these implications.

e) Develop a set of policy options in relation to these elements that takes account of the available evidence.

f) Assess the strengths and weaknesses of these options.

g) Prepare a set of recommendations regarding optimal and/or desirable policy approaches.

ATTACHMENT E

INDIGENOUS

Author: John Boffa

Task:

Identify the key approaches and actions that need to be taken to reduce the high burden of disease due to obesity, tobacco and alcohol among Indigenous Australians that should be included in the National Preventative Health Strategy. This should take into account:

- the respective needs of metropolitan and remote Indigenous communities;
- existing measures addressing obesity, alcohol and tobacco;
- analysis of impediments to modifying risky behaviours and possible motivational drivers of behavioural change;
- the role of different potential agents of change, including family, community, primary care, and population level interventions;
- new approaches to environmental change and behavioural change which might be considered for inclusion in the National Preventative Health Strategy with a view to supporting the Government's objective of closing the gap in Indigenous health within a generation.

ATTACHMENT F

INFRASTRUCTURE

Author: Randall Kent

Task: **Identify the key elements of infrastructure required to support and implement the actions outlined in the National Preventative Health Strategy, specifically the establishment and function of a National Prevention Agency.**

Specifically:

Outline:

- Key messages to support the call to action
- A succinct rationale for action on infrastructure
- Targets including interim targets (if required)
- Priority areas for action
- Business case for each priority area
- Template for action including (if required):
    - What
    - When
    - Who by / With
    - How measured

Considerations in developing this work are expected to include at a minimum:

- The establishment of a National Prevention Agency including:
    - Preferred models
    - Governance
    - Funding
    - Staffing / Expertise
    - Role and Functions
- Data, Monitoring and Surveillance
- Social Marketing
- Research and Evaluation
- Prevention Workforce

ATTACHMENT G

CHILD AND MATERNAL HEALTH

Author: Sharon Goldfeld and Frank Oberklaid

Task: **Develop a research paper to investigate the importance of the early years on health.**

Aim of paper: To investigate the importance of the early years as the key to preventative health.

a) Include issues relating to maternal health during pregnancy.

b) Provide 4-5 policy options that Australia should pursue relating to the importance of the early years / children in a preventative health strategy.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-315

OUTCOME 1: Population Health

Topic: HEPATITIS C TESTS

Written Question on Notice

Senator Heffernan asked:

a) Did the Department ever conduct an inquiry into the accuracy of hepatitis C virus tests and the impact of those tests on the provision of healthcare in Australia?

b) If so, elaborate. If not, why not?

Answer:

a) The Therapeutic Goods Administration assesses the performance of Hepatitis C test kits before approving their supply in Australia, including their accuracy. The Department provides funding to the National Serology Reference Laboratory to confirm the ongoing quality of HIV and Hepatitis C virus test kits and provide a comprehensive quality assurance program for laboratories using these test kits.

b) The reports received from the National Serology Reference Laboratory on the validation of Hepatitis C tests do not indicate that there is a need for an inquiry into the accuracy of Hepatitis C test kits.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-146

OUTCOME 1: Population Health

Topic: CERVICAL CANCER SCREENING

Hansard Page: CA 93

Senator Humphries asked:

Do you have that by state (figures for 2006 and 2007 cervical screening program)?

Answer:

Provided below are tables on two and three yearly participation in the National Cervical Screening Program as reported by the Australian Institute of Health and Welfare in the Program monitoring reports.

Participation in the National Cervical Screening Program for the two year period 2006-2007

	Percent (%)	Number of women screened	
		Aged 20+	Aged 20-69
NSW	60.3	1,160,175	1,142,645
Vic	64.3	940,800	928,147
Qld	59.2	690,236	679,309
WA	60.2	351,393	346,769
SA	63.8	281,906	275,931
Tas	60.7	82,480	81,468
ACT	63.3	63,684	63,096
NT	53.1	32,320	32,159
Australia	**61.5**	**3,602,994**	**3,549,524**

Source: Australian Institute of Health and Welfare 2009. *Cervical screening in Australia 2006-2007*. Cancer series no. 47. Cat. No. CAN 43. Canberra: AIHW

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-147

OUTCOME 1: Population Health

Topic: BOWEL CANCER SCREENING

Hansard Page: CA 97

Senator Ryan asked:

The increase in the number of these procedures that has occurred since the introduction of this program.

Answer:

From the limited data available, there appears to have been little or no increase in the number of colonoscopies for public patients since the introduction of the Program beyond the growth trend already associated with this procedure.

The National Bowel Cancer Screening Program has been introduced in a phased approach. From August 2006, 55 and 65 year-olds commenced screening and 50 year-olds commenced in July 2008.

The table at Attachment A presents data on the number of publicly funded colonoscopies per year by age group from 2003-04 to 2007-08.

Attachment A

Number of colonoscopies performed for public patients 2003-04 to 2007-08

Age group	2003-04	2004-05	2005-06	2006-07	2007-08
	Number of separations				
50 to 54	10,142	10,384	10,869	11,199	10,950
55 to 59	11,605	11,529	12,054	12,700	13,562
60 to 64	11,870	12,397	12,292	12,790	12,905
65 to 69	12,972	13,326	13,508	14,116	14,960
Total	**46,589**	**47,636**	**48,723**	**50,805**	**52,377**
	Annual increase (%)				
50 to 54		2.4	4.7	3.0	-2.2
55 to 59		-0.7	4.6	5.4	6.8
60 to 64		4.4	-0.8	4.1	0.9
65 to 69		2.7	1.4	4.5	6.0
Total		**2.2**	**2.3**	**4.3**	**3.1**

Source: National Admitted Patient Care data 2003-04 to 2007-08

Notes: 1) Separations for which care type was reported as Newborn with no qualified days,and records for Hospital boarders and Posthumous organ procurement have been excluded. 2) Public patients defined as follows: patients with funding source of AHCA or Reciprocal health care agreements (with other countries); or funding source of Other hospital or public authority (contracted care) AND patient election status is Public; or funding source of Other AND patient election status is Public; or funding source of No charge raised AND patient election status is Public. 3) Hospital codes included in table are 32090-00, 32090-01, 32093-00, 32084-00, 32084-01, 32087-00, 32094-00, 30479-01, 30479-02, 90308-00, 90312-01 and 30375-23.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-148

OUTCOME 1: Population Health

Topic: BOWEL CANCER SCREENING

Hansard Page: CA 98

Senator Adams asked:

a) As far as the kits that were first sent out, do you have any data on the number that were returned because of people moving or because they are just not there, and they have come back to the department?

b) Do you have figure on that?

Answer:

a) Yes.

b) On average, approximately 2.1% of the mail issued under the National Bowel Cancer Screening Program (the Program) is returned to the Program's Register. In May 2009, the Commonwealth Chief Medical Officer sent letters to the 389,911 individuals who had been issued with faulty faecal occult blood test kits since 1 December 2008. Of these, 1,840 (0.5%) letters had been returned to the Program Register, as at 24 June 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-336

OUTCOME 1: Population Health

Topic: TOBACCO TAXES

Hansard Page: CA 102

Senator Ryan asked:

a) Has the Department provided advice to the Minister regarding tobacco taxes?
b) I was after the dates, since 1 July last year, on which the Department provided advice to the Minister with respect to tobacco taxes.

Answer:

a) Yes, the Department has provided advice to the Minister regarding tobacco taxes.

b) The dates, since 1 July last year, on which the Department provided advice to the Minister with respect to tobacco taxes are:

5 December 2008;
15 January 2009;
30 April 2009;
11 May 2009;
12 May 2009; and
12 June 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-056

OUTCOME 2: Access to Pharmaceutical Services

Topic: INTRODUCTION OF NOVEL MEDICINES

Written Question on Notice

Senator Abetz asked:

How does the present government intend to address the lack of timely introduction of novel medicines/therapies for the Australian population once data has been made public?

Answer:

Under the *Therapeutic Goods Act 1989* (the Act) all medical products to be imported into, supplied in, or exported from Australia required to be included in the Australian Register of Therapeutic Goods (ARTG).

In order for a product to be included in the ARTG, a sponsor is required to make an application to the TGA. To facilitate the application process for sponsors the format used when seeking registration is consistent with other international regulatory agencies and the information on safety and efficacy to be provided based on internally harmonised guidelines. The Act also mandates a maximum time for evaluation (255 working days) which is consistent with other regulatory agencies.

The TGA is unable to approve a product without an application and is unable to compel a company to apply to register a product.

In cases where a new medicine offers a benefit in the treatment of a serious disease, priority review is given to those applications.

The TGA would usually seek the advice of the independent expert advisory committee, the Australian Drug and Evaluation Committee (ADEC), before making a decision to approve a new medicine.

Once registered, the medicine is approved for supply but it is the sponsor who determines when the medicine will be available and whether they will seek to be included in the Pharmaceutical Benefits Schedule.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3&4 June 2009

Question: E09-058

OUTCOME 2: Access to Pharmaceutical Services

Topic: UNPROVEN THERAPIES

Written Question on Notice

Senator Abetz asked:

How does the present government intend to address the extraordinary waste of money on unproven therapies that mislead the public and many indeed do harm?

Answer:

The Therapeutic Goods Administration (TGA) does not regulate therapies, nor does the TGA regulate the way in which health practitioners conduct their professional practice. The practices of healthcare practitioners is governed and controlled by the individual state and territory governments.

The TGA has responsibility for administering the *Therapeutic Goods Act 1989* which provides the national framework for the regulation of therapeutic goods in Australia. The TGA adopts a risk management approach to regulation where the level of regulatory control of a therapeutic product is based on the assessed level of safety of the product and the seriousness of the condition for which it is intended to be used. Most therapeutic products must be entered on the Australian Register of Therapeutic Goods (ARTG) before they can be supplied in Australia. Overall control of the supply of therapeutic products is exercised through:

- pre-market assessment before a therapeutic product can be supplied on the market;
- licensing of Australian medicinal product manufacturers, clearance of overseas medicinal product manufacturers and certification of device manufacturer quality systems; and
- post-market monitoring and enforcement of compliance with standards and advertising controls, and review of adverse event reports for therapeutic products.

The Government is committed to improving access to regulatory information gathered or generated by the TGA so that the public can be better informed about therapeutic products approved for use in Australia. A number of initiatives have recently been introduced that improve the TGA's transparency and communication of information, including giving the public access to a greater level of details on therapeutic products on the ARTG. The availability of a wider range of information should assist the Australian public and health professionals when making decisions about their use of approved therapeutic products.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-042

OUTCOME 2: Access to Pharmaceutical Services

Topic: PBS – PRICE CHANGES

Written Question on Notice

Senator Ryan asked:

a) How many individual medicines listed on the PBS have decreased in price over the past two years, and what were those drugs and the price decrease?
b) How many individual medicines listed on the PBS have increased in price over the past two years, and what were those drugs and the price increase?

Answer:

The Department does not have systems that would enable the ready production of a list of medicines with price changes. This aspect of the question would involve a significant and unreasonable diversion of Department of Health and Ageing resources. The information provided gives the total number of medicines affected and the types of reasons why individual medicines may have had a change in price. Some medicines may incur both a price increase and a price decrease over the specified period.

a) Between 1 June 2007 and 1 June 2009, there were 502 medicines (including different forms/strengths and maximum quantities) where the Commonwealth dispensed price for maximum quantity decreased. The decreases ranged from 1 cent to $214.87.
b) Between 1 June 2007 and 1 June 2009, there were 1,348 medicines (including different forms/strengths and maximum quantities) where the Commonwealth dispensed price for maximum quantity increased. The increases ranged from 1 cent to $1,569.40.

Changes in the price of individual medicines can be due to a number of reasons including:

- An increase in price as a result of adjustment to the dispensing fee, pharmacy mark-ups and additional fees as provided for in the Fourth Community Pharmacy Agreement;
- An increase in price as a result of the annual review or ad-hoc review of prices by the Pharmaceutical Benefits Pricing Authority;
- A decrease in price as a result of a statutory price reduction;
- A decrease in price as a result of a manufacturer offering an ad hoc price reduction; and
- An increase or decrease in price as a result of the manufacturer initiating or changing their brand price premium.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-043

OUTCOME 2: Access to Pharmaceutical Services

Topic: BRAND PREMIUM

Written Question on Notice

Senator Ryan asked:

a) How many medicines have had a brand premium applied?

b) What were the items, and what is the premium?

Answer:

a) As at 1 June 2009, there were 309 branded products which had a brand premium applied.

b) The number of medicines which had a brand premium applied is shown in Attachment A. This list combines some branded products where there are two different premiums for one product. This happens when a medicine can be dispensed with different maximum quantities.

Attachment A

Drug Name	Form and Strength	Brand premium
ACICLOVIR	Tablet 200 mg	$3.21 to $4.34
ACICLOVIR	Tablet 800 mg	$1.56 to $5.19
ALENDRONATE SODIUM	Tablet equivalent to 70 mg alendronic acid	$1.42
ALLOPURINOL	Tablet 100 mg	$1.91
ALLOPURINOL	Tablet 300 mg	$1.80
ALPRAZOLAM	Tablet 1 mg	$1.32
ALPRAZOLAM	Tablet 2 mg	$1.60
ALPRAZOLAM	Tablet 250 micrograms	$1.04
ALPRAZOLAM	Tablet 500 micrograms	$1.12
AMLODIPINE	Tablet 10 mg (as besylate)	$5.68
AMLODIPINE	Tablet 5 mg (as besylate)	$3.91
AMOXYCILLIN	Capsule 250 mg	$0.79
AMOXYCILLIN	Capsule 500 mg	$0.80
AMOXYCILLIN	Powder for syrup 125 mg per 5 mL, 100 mL	$0.95
AMOXYCILLIN	Powder for syrup 250 mg per 5 mL, 100 mL	$0.79
AMOXYCILLIN	Tablet 1 g	$1.17
AMOXYCILLIN with CLAVULANIC ACID	Powder for syrup 125 mg-31.25 mg per 5 mL, 75 mL	$1.51
AMOXYCILLIN with CLAVULANIC ACID	Powder for syrup 400 mg-57 mg per 5 mL, 60 mL	$1.54
AMOXYCILLIN with CLAVULANIC ACID	Tablet 500 mg-125 mg	$1.55
AMOXYCILLIN with CLAVULANIC ACID	Tablet 875 mg-125 mg	$2.04
ASPIRIN	Tablet 100 mg	$1.36
ATENOLOL	Tablet 50 mg	$3.54
BACLOFEN	Tablet 10 mg	$2.26
BACLOFEN	Tablet 25 mg	$2.18
BETAMETHASONE VALERATE	Cream 200 micrograms (base) per g (0.02%), 100 g	$6.18
BETAMETHASONE VALERATE	Cream 500 micrograms (base) per g (0.05%), 15 g	$1.91
BETAMETHASONE VALERATE	Ointment 500 micrograms (base) per g (0.05%), 15 g	$1.91
BETAXOLOL HYDROCHLORIDE	Eye drops, solution, 5 mg (base) per mL (0.5%), 5 mL	$2.18
BISACODYL	Suppositories 10 mg, 10	$1.14
BLEOMYCIN SULFATE	Powder for injection 15,000 i.u.	$67.34
BLEOMYCIN SULFATE	Powder for injection 15,000 i.u. (solvent required)	$75.30
BRIMONIDINE TARTRATE	Eye drops 2 mg per mL (0.2%), 5 mL	$1.74
BRINZOLAMIDE	Eye drops 10 mg per mL (1%), 5 mL	$1.23
BROMOCRIPTINE MESYLATE	Capsule 10 mg (base)	$3.08
BROMOCRIPTINE MESYLATE	Capsule 5 mg (base)	$2.91

BROMOCRIPTINE MESYLATE	Tablet 2.5 mg (base)	$2.84 to $2.92
BUPROPION HYDROCHLORIDE	Tablet 150 mg (sustained release)	$0.85 to $0.86
CALCIUM FOLINATE	Injection equivalent to 50 mg folinic acid in 5 mL	$0.10
CAPTOPRIL	Tablet 25 mg	$3.67
CAPTOPRIL	Tablet 50 mg	$3.66
CARBAMAZEPINE	Tablet 100 mg	$2.55
CARBAMAZEPINE	Tablet 200 mg	$2.74
CARBOMER	Eye gel 2 mg per g (0.2%), 10 g	$1.00
CEFACLOR	Powder for oral suspension 125 mg per 5 mL, 100 mL	$4.18
CEFACLOR	Powder for oral suspension 250 mg per 5 mL, 75 mL	$4.37
CEFACLOR	Tablet 375 mg (sustained release)	$5.20
CEFOTAXIME	Powder for injection 1 g	$25.10
CEFOTAXIME	Powder for injection 2 g	$46.50
CEPHALEXIN	Capsule 250 mg	$3.30
CEPHALEXIN	Capsule 500 mg	$4.41
CEPHALEXIN	Granules for syrup 125 mg per 5 mL, 100 mL	$3.55
CEPHALEXIN	Granules for syrup 250 mg per 5 mL, 100 mL	$4.38
CIMETIDINE	Tablet 200 mg	$1.94
CIMETIDINE	Tablet 400 mg	$1.94
CIPROFLOXACIN	Eye drops 3 mg per mL (0.3%), 5 mL	$2.06
CIPROFLOXACIN	Tablet 250 mg	$1.45
CIPROFLOXACIN	Tablet 500 mg	$1.26
CIPROFLOXACIN	Tablet 750 mg	$1.37
CITALOPRAM HYDROBROMIDE	Tablet 20 mg (base)	$4.45
CLARITHROMYCIN	Tablet 250 mg	$1.96
CLINDAMYCIN	Capsule 150 mg	$1.45
CLOMIPHENE CITRATE	Tablet 50 mg	$0.14 to $3.9
CLOMIPRAMINE HYDROCHLORIDE	Tablet 25 mg	$3.26
CLONAZEPAM	Tablet 2 mg	$2.04 to $4.08
CLONAZEPAM	Tablet 500 micrograms	$1.79 to $3.58
CODEINE PHOSPHATE with PARACETAMOL	Tablet 30 mg-500 mg	$2.8 to $8.4
COLCHICINE	Tablet 500 micrograms	$0.91
CYCLOSPORIN	Capsule 100 mg	$1.06 to $2.26
CYCLOSPORIN	Capsule 25 mg	$0.97 to $2.28
CYCLOSPORIN	Capsule 50 mg	$1.05 to $2.24
CYPROTERONE ACETATE	Tablet 100 mg	$1.65
CYPROTERONE ACETATE	Tablet 50 mg	$3 to $3.13
DESFERRIOXAMINE MESYLATE	Powder for injection 2 g	$0.39
DESFERRIOXAMINE MESYLATE	Powder for injection 500 mg	$8.03
DEXAMETHASONE with FRAMYCETIN SULFATE and GRAMICIDIN	Ear drops 500 micrograms-5 mg-50 micrograms per mL, 8 mL	$2.00

DIAZEPAM	Tablet 2 mg	$0.59 to $0.86
DIAZEPAM	Tablet 5 mg	$0.63 to $0.88
DICLOFENAC SODIUM	Tablet 25 mg (enteric coated)	$1.96
DICLOFENAC SODIUM	Tablet 50 mg (enteric coated)	$1.96
DIGOXIN	Tablet 250 micrograms	$1.80
DIGOXIN	Tablet 62.5 micrograms	$1.79
DIPHENOXYLATE HYDROCHLORIDE with ATROPINE SULFATE	Tablet 2.5 mg-25 micrograms	$1.83
DOTHIEPIN HYDROCHLORIDE	Capsule 25 mg	$1.58
DOTHIEPIN HYDROCHLORIDE	Tablet 75 mg	$0.81
DOXEPIN HYDROCHLORIDE	Capsule 10 mg (base)	$1.87
DOXEPIN HYDROCHLORIDE	Capsule 25 mg (base)	$1.57
DOXYCYCLINE	Capsule 100 mg (as hydrochloride)	$1.15 to $4.6
DOXYCYCLINE	Capsule 50 mg (as hydrochloride)	$1.31
DOXYCYCLINE	Tablet 100 mg (as hydrochloride)	$1.19 to $4.76
DOXYCYCLINE	Tablet 50 mg (as hydrochloride)	$1.25
ENALAPRIL MALEATE	Tablet 10 mg	$2.46 to $4.3
ENALAPRIL MALEATE	Tablet 20 mg	$2.47 to $4.3
ENALAPRIL MALEATE	Tablet 5 mg	$4.30
ERYTHROMYCIN	Capsule 250 mg	$1.35
ERYTHROMYCIN ETHYL SUCCINATE	Powder for oral liquid 200 mg (base) per 5 mL, 100 mL	$2.86
ERYTHROMYCIN ETHYL SUCCINATE	Powder for oral liquid 400 mg (base) per 5 mL, 100 mL	$2.89
ERYTHROMYCIN ETHYL SUCCINATE	Tablet 400 mg (base)	$2.80
ESCITALOPRAM OXALATE	Tablet 10 mg (base)	$4.89
ESCITALOPRAM OXALATE	Tablet 20 mg (base)	$7.16
FAMOTIDINE	Tablet 20 mg	$4.25
FAMOTIDINE	Tablet 40 mg	$5.41
FELODIPINE	Tablet 10 mg (extended release)	$5.00
FELODIPINE	Tablet 2.5 mg (extended release)	$5.00
FELODIPINE	Tablet 5 mg (extended release)	$5.00
FLUOXETINE HYDROCHLORIDE	Capsule 20 mg (base)	$4.13
FLUOXETINE HYDROCHLORIDE	Tablet 20 mg (base) (dispersible)	$4.13
FLUVASTATIN SODIUM	Capsule 20 mg (fluvastatin)	$3.28
FLUVASTATIN SODIUM	Capsule 40 mg (fluvastatin)	$3.58
FLUVOXAMINE MALEATE	Tablet 100 mg	$2.95
FLUVOXAMINE MALEATE	Tablet 50 mg	$2.96
FRUSEMIDE	Tablet 20 mg	$1.90
FRUSEMIDE	Tablet 40 mg	$2.40
GABAPENTIN	Capsule 100 mg	$1.00
GABAPENTIN	Capsule 300 mg	$0.99
GABAPENTIN	Capsule 400 mg	$1.00
GABAPENTIN	Tablet 600 mg	$1.00
GABAPENTIN	Tablet 800 mg	$1.00
GEMFIBROZIL	Tablet 600 mg	$2.95
GLIBENCLAMIDE	Tablet 5 mg	$1.51
GLICLAZIDE	Tablet 80 mg	$2.03

GLIMEPIRIDE	Tablet 1 mg	$2.81
GLIMEPIRIDE	Tablet 2 mg	$2.81
GLIMEPIRIDE	Tablet 3 mg	$2.80
GLIMEPIRIDE	Tablet 4 mg	$2.80
GLIPIZIDE	Tablet 5 mg	$4.07
GLYCERYL TRINITRATE	Tablets 600 micrograms, 100	$1.64
HYDROCORTISONE ACETATE	Cream 10 mg per g (1%), 30 g	$1.90
HYDROCORTISONE ACETATE	Cream 10 mg per g (1%), 50 g	$0.08 to $1.91
HYDROCORTISONE ACETATE	Topical ointment 10 mg per g (1%), 30 g	$1.90
HYDROCORTISONE ACETATE	Topical ointment 10 mg per g (1%), 50 g	$1.91
HYPROMELLOSE	Eye drops 3 mg per mL (0.3%), 15 mL	$1.86
HYPROMELLOSE with CARBOMER 980	Ocular lubricating gel 3 mg-2 mg per g (0.3%-0.2%), 10 g	$1.86
HYPROMELLOSE with DEXTRAN	Eye drops 3 mg-1 mg per mL (0.3%-0.1%), 15 mL	$1.87
IMIPRAMINE HYDROCHLORIDE	Tablet 10 mg	$2.97
IMIPRAMINE HYDROCHLORIDE	Tablet 25 mg	$2.97
INDAPAMIDE HEMIHYDRATE	Tablet 2.5 mg	$2.56
INDOMETHACIN	Capsule 25 mg	$0.92
IPRATROPIUM BROMIDE	Nebuliser solution single dose units 250 micrograms	$0.72
IPRATROPIUM BROMIDE	Nebuliser solution single dose units 500 micrograms	$0.62
ISOSORBIDE MONONITRATE	Tablet 120 mg (sustained release)	$3.00
ISOSORBIDE MONONITRATE	Tablet 60 mg (sustained release)	$2.84
ISOTRETINOIN	Capsule 20 mg	$2.37
KETOPROFEN	Capsule 200 mg (sustained release)	$2.30
LABETALOL HYDROCHLORIDE	Tablet 100 mg	$2.99
LABETALOL HYDROCHLORIDE	Tablet 200 mg	$2.97
LACTULOSE	Mixture 3.34 g per 5 mL, 500 mL	$1.67
LAMOTRIGINE	Tablet 100 mg	$0.73
LAMOTRIGINE	Tablet 200 mg	$0.72
LAMOTRIGINE	Tablet 25 mg	$0.77
LAMOTRIGINE	Tablet 5 mg	$0.76
LAMOTRIGINE	Tablet 50 mg	$0.66
LEVODOPA with CARBIDOPA	Tablet 100 mg-25 mg	$5.22
LEVODOPA with CARBIDOPA	Tablet 250 mg-25 mg	$3.10
LEVONORGESTREL with ETHINYLOESTRADIOL	Pack containing 21 tablets 150 micrograms-30 micrograms and 7 inert tablets	$12.25 to $12.69

LEVONORGESTREL with ETHINYLOESTRADIOL	Pack containing 6 tablets 50 micrograms-30 micrograms, 5 tablets 75 micrograms-40 micrograms, 10 tablets	$12.25 to $12.69
LEVONORGESTREL with ETHINYLOESTRADIOL	Tablets 150 micrograms-30 micrograms, 21	$12.69
LISINOPRIL	Tablet 10 mg	$2.08 to $3.35
LISINOPRIL	Tablet 20 mg	$2.08 to $3.35
LISINOPRIL	Tablet 5 mg	$2.08 to $3.35
LOPERAMIDE HYDROCHLORIDE	Capsule 2 mg	$0.94
MEDROXYPROGESTERONE ACETATE	Injection 150 mg in 1 mL	$3.34
MEDROXYPROGESTERONE ACETATE	Tablet 10 mg	$1.64 to $1.75
MEDROXYPROGESTERONE ACETATE	Tablet 5 mg	$1.74
MELOXICAM	Tablet 15 mg	$1.63
MELOXICAM	Tablet 7.5 mg	$1.61
METFORMIN HYDROCHLORIDE	Tablet 1 g	$1.80
METFORMIN HYDROCHLORIDE	Tablet 500 mg	$1.1 to $1.79
METFORMIN HYDROCHLORIDE	Tablet 850 mg	$1.1 to $1.79
METHYLDOPA	Tablet 250 mg	$2.24
METHYLPREDNISOLONE ACETATE	Injection 40 mg in 1 mL	$0.76
METOCLOPRAMIDE HYDROCHLORIDE	Tablet 10 mg	$3.02
METOPROLOL TARTRATE	Tablet 100 mg	$2.35 to $3.25
METOPROLOL TARTRATE	Tablet 50 mg	$2.35 to $3.25
METRONIDAZOLE	Tablet 200 mg	$2.30
METRONIDAZOLE	Tablet 400 mg	$2.30
MIANSERIN HYDROCHLORIDE	Tablet 10 mg	$1.99
MIANSERIN HYDROCHLORIDE	Tablet 20 mg	$2.97
MINOCYCLINE	Tablet 50 mg	$0.85
MIRTAZAPINE	Tablet 30 mg	$1.70
MIRTAZAPINE	Tablet 45 mg	$1.49
MOCLOBEMIDE	Tablet 150 mg	$0.72
MOCLOBEMIDE	Tablet 300 mg	$1.45
NAPROXEN	Tablet 1 g (sustained release)	$1.34
NAPROXEN	Tablet 250 mg	$2.34
NAPROXEN	Tablet 500 mg	$1.36
NAPROXEN	Tablet 750 mg (sustained release)	$1.27
NAPROXEN SODIUM	Tablet 550 mg	$2.29
NIFEDIPINE	Tablet 10 mg	$1.17
NIFEDIPINE	Tablet 20 mg	$2.21
NIFEDIPINE	Tablet 30 mg (controlled release)	$2.54
NIFEDIPINE	Tablet 60 mg (controlled release)	$2.81
NITRAZEPAM	Tablet 5 mg	$1.53 to $3.06
NIZATIDINE	Capsule 150 mg	$5.60
NIZATIDINE	Capsule 300 mg	$5.60

NORETHISTERONE	Tablets 350 micrograms, 28	$4.00
NORETHISTERONE with ETHINYLOESTRADIOL	Pack containing 12 tablets 500 micrograms-35 micrograms, 9 tablets 1 mg-35 micrograms and 7 inert tablets	$7.92
NORETHISTERONE with ETHINYLOESTRADIOL	Pack containing 21 tablets 1 mg-35 micrograms and 7 inert tablets	$7.92
NORETHISTERONE with ETHINYLOESTRADIOL	Pack containing 21 tablets 500 micrograms-35 micrograms and 7 inert tablets	$7.92
NORETHISTERONE with ETHINYLOESTRADIOL	Tablets 1 mg-35 micrograms, 21	$7.92
NORETHISTERONE with ETHINYLOESTRADIOL	Tablets 500 micrograms-35 micrograms, 21	$7.92
NORFLOXACIN	Tablet 400 mg	$3.62
OMEPRAZOLE	Tablet 20 mg (as magnesium)	$2.75
ONDANSETRON	I.V. injection 4 mg in 2 mL	$0.57 to $0.7
ONDANSETRON	I.V. injection 8 mg in 4 mL	$0.56 to $0.69
ONDANSETRON	Tablet 4 mg	$0.56 to $0.69
ONDANSETRON	Tablet 8 mg	$0.57 to $0.69
ONDANSETRON	Wafer 4 mg	$0.56 to $0.69
ONDANSETRON	Wafer 8 mg	$0.57 to $0.69
OXAZEPAM	Tablet 15 mg	$1.78 to $3.56
OXAZEPAM	Tablet 30 mg	$1.9 to $3.8
PARAFFIN	Compound eye ointment 3.5 g	$2.24
PARAFFIN	Pack containing 2 tubes compound eye ointment 3.5 g	$2.24
PAROXETINE	Tablet 20 mg (as hydrochloride)	$0.86
PINDOLOL	Tablet 15 mg	$2.69
PINDOLOL	Tablet 5 mg	$2.71
PIROXICAM	Capsule 10 mg	$2.66
PIROXICAM	Capsule 20 mg	$2.64
PIROXICAM	Dispersible tablet 20 mg	$2.64
POLYVINYL ALCOHOL	Eye drops 14 mg per mL (1.4%), 15 mL	$1.71
POLYVINYL ALCOHOL	Eye drops 30 mg per mL (3%), 15 mL	$5.94
POTASSIUM CHLORIDE	Tablet 600 mg (sustained release)	$2.80
POTASSIUM CHLORIDE with POTASSIUM BICARBONATE	Effervescent tablet 14 mmol potassium and 8 mmol chloride	$2.61
PRAVASTATIN SODIUM	Tablet 10 mg	$3.52
PRAVASTATIN SODIUM	Tablet 20 mg	$3.52
PRAVASTATIN SODIUM	Tablet 40 mg	$3.07
PRAVASTATIN SODIUM	Tablet 80 mg	$3.37
PRAZOSIN HYDROCHLORIDE	Tablet 1 mg (base)	$2.95
PRAZOSIN HYDROCHLORIDE	Tablet 2 mg (base)	$3.04
PRAZOSIN HYDROCHLORIDE	Tablet 5 mg (base)	$3.29
PREDNISOLONE	Tablet 1 mg	$0.46
PREDNISOLONE SODIUM PHOSPHATE	Oral solution equivalent to 5 mg prednisolone per mL, 30 mL	$1.86
PREDNISONE	Tablet 1 mg	$0.65
PROCHLORPERAZINE	Tablet containing prochlorperazine maleate 5 mg	$2.50

PROPRANOLOL HYDROCHLORIDE	Tablet 10 mg	$3.14
PROPRANOLOL HYDROCHLORIDE	Tablet 40 mg	$3.14
QUINAPRIL HYDROCHLORIDE	Tablet 10 mg (base)	$0.66
QUINAPRIL HYDROCHLORIDE	Tablet 20 mg (base)	$0.99
QUINAPRIL HYDROCHLORIDE	Tablet 5 mg (base)	$0.49
QUININE SULFATE	Tablet 300 mg	$2.17
RANITIDINE HYDROCHLORIDE	Tablet 150 mg (base)	$1.71
RANITIDINE HYDROCHLORIDE	Tablet 300 mg (base)	$1.71
ROXITHROMYCIN	Tablet 150 mg	$2.60
ROXITHROMYCIN	Tablet 300 mg	$2.60
SALBUTAMOL SULFATE	Nebuliser solution single dose units 2.5 mg (base) in 2.5 mL, 30	$1.46
SALBUTAMOL SULFATE	Nebuliser solution single dose units 5 mg (base) in 2.5 mL, 30	$1.46
SALBUTAMOL SULFATE	Oral pressurised inhalation 100 micrograms (base) per dose (200 doses)	$1.18
SERTRALINE HYDROCHLORIDE	Tablet 100 mg (base)	$1.49
SERTRALINE HYDROCHLORIDE	Tablet 50 mg (base)	$1.49
SIMVASTATIN	Tablet 10 mg	$2.95
SIMVASTATIN	Tablet 20 mg	$2.95
SIMVASTATIN	Tablet 40 mg	$2.95
SIMVASTATIN	Tablet 5 mg	$2.95
SIMVASTATIN	Tablet 80 mg	$2.95
SODIUM VALPROATE	Tablet 200 mg (enteric coated)	$1.50
SODIUM VALPROATE	Tablet 500 mg (enteric coated)	$1.50
SOTALOL HYDROCHLORIDE	Tablet 160 mg	$4.50
SOTALOL HYDROCHLORIDE	Tablet 80 mg	$4.50
SPIRONOLACTONE	Tablet 100 mg	$2.53
SPIRONOLACTONE	Tablet 25 mg	$1.84
SUCRALFATE	Tablet equivalent to 1 g anhydrous sucralfate	$2.18
SULFASALAZINE	Tablet 500 mg (enteric coated)	$1.60
TAMOXIFEN CITRATE	Tablet 20 mg (base)	$3.82
TEMAZEPAM	Tablet 10 mg	$1.38 to $2.76
TERBINAFINE HYDROCHLORIDE	Tablet 250 mg (base)	$1.46
THYROXINE SODIUM	Tablet equivalent to 100 micrograms anhydrous thyroxine sodium	$1.31
THYROXINE SODIUM	Tablet equivalent to 200 micrograms anhydrous thyroxine sodium	$1.29
THYROXINE SODIUM	Tablet equivalent to 50 micrograms anhydrous thyroxine sodium	$1.30
THYROXINE SODIUM	Tablet equivalent to 75 micrograms anhydrous thyroxine sodium	$1.46

TIMOLOL MALEATE	Eye drops 2.5 mg (base) per mL (0.25%), 5 mL	$2.95
TIMOLOL MALEATE	Eye drops 5 mg (base) per mL (0.5%), 5 mL	$2.95
TINIDAZOLE	Tablet 500 mg	$2.51
TRAMADOL HYDROCHLORIDE	Capsule 50 mg	$2.42
TRAMADOL HYDROCHLORIDE	Tablet 100 mg (twice daily sustained release)	$4.51
TRAMADOL HYDROCHLORIDE	Tablet 150 mg (twice daily sustained release)	$5.37
TRAMADOL HYDROCHLORIDE	Tablet 200 mg (twice daily sustained release)	$6.09
TRANDOLAPRIL	Capsule 1 mg	$1.57
TRANDOLAPRIL	Capsule 2 mg	$1.58
TRANDOLAPRIL	Capsule 4 mg	$1.57
TRANDOLAPRIL	Capsule 500 micrograms	$1.57
TRIAMCINOLONE ACETONIDE	Cream 200 micrograms per g (0.02%), 100 g	$3.30
TRIAMCINOLONE ACETONIDE	Ointment 200 micrograms per g (0.02%), 100 g	$3.30
TRIAMCINOLONE ACETONIDE with NEOMYCIN SULFATE, GRAMICIDIN and NYSTATIN	Ear drops 1 mg-2.5 mg (base)	$1.07
TRIAMCINOLONE ACETONIDE with NEOMYCIN SULFATE, GRAMICIDIN and NYSTATIN	Ear ointment 1 mg-2.5 mg (base)	$1.08
TRIMETHOPRIM	Tablet 300 mg	$1.03
TRIMETHOPRIM with SULFAMETHOXAZOLE	Oral suspension 40 mg-200 mg per 5 mL, 100 mL	$1.46
TRIMETHOPRIM with SULFAMETHOXAZOLE	Tablet 160 mg-800 mg	$1.10
VERAPAMIL HYDROCHLORIDE	Tablet 180 mg (sustained release)	$2.27
VERAPAMIL HYDROCHLORIDE	Tablet 240 mg (sustained release)	$2.26
VERAPAMIL HYDROCHLORIDE	Tablet 40 mg	$0.76
VERAPAMIL HYDROCHLORIDE	Tablet 80 mg	$0.76

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-044

OUTCOME 2: Access to Pharmaceutical Services

Topic: SPECIAL PATIENT CONTRIBUTION

Written Question on Notice

Senator Ryan asked:

Have any medicines had Special Patient Contribution applied to them?

Answer:

Special Patient Contributions can be a brand premium, a therapeutic group premium, or an other special patient contribution. It is possible for a product to have both a brand premium and a therapeutic group premium.

At 30 June 2009, of the 3,394 products listed on the Pharmaceutical Benefits Scheme 326 products had a Special Patient Contribution:

- 309 products had a brand premium;
- 7 products had a therapeutic group premium; and
- 12 products had an other special patient contribution.

Two of these products had both a brand premium and a therapeutic group premium. Therefore the total does not equal the sum of the component categories.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-045

OUTCOME 2: Access to Pharmaceutical Services

Topic: SPECIAL PATIENT CONTRIBUTION

Written Question on Notice

Senator Ryan asked:

Is consideration, discussion or other consultation currently underway with the Department, Pharmaceutical Benefits Pricing Authority and/or any manufacturer with respect to applying such a Special Patient Contribution to any item on the PBS Schedule?

Answer:

With 3,394 products listed on the Pharmaceutical Benefits Scheme (at 30 June 2009), there are ongoing discussions with manufacturers about the price of medicines including Special Patient Contributions.

Advice about Special Patient Contributions has been provided in response to Question Number E09-044.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-055

OUTCOME 2: Access to Pharmaceutical Services

Topic: COST OF THE PBS ONCOLOGY

Written Question on Notice

Senator Abetz asked:

What is the cost/QALY acceptable to the PBS for oncology in early stage and late stage disease and why?

Answer:

The Pharmaceutical Benefits Advisory Committee (PBAC) has not adopted specific cost/Quality Adjusted Life Years (QALY) limits in respect of any medicine.

Quality Adjusted Life Years take into account the characteristics of the proposed treatment and of its comparator in terms of efficacy and side-effects, which impact on the extension of life and quality of life. This concept is applied to all drugs regardless of therapeutic area or stage of the disease.

The PBAC is an independent Statutory Committee; the government does not seek to influence its decisions which are based on expert analysis of the evidence presented.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

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Question: E09-057

OUTCOME 2: Access to Pharmaceutical Services

Topic: INTRODUCTION OF NOVEL MEDICINES

Written Question on Notice

Senator Abetz asked:

How does the present government intend to address the lack of dialogue between drug development companies and the TGA/PBS so that the timely introduction of novel medicines/therapies can be minimised for the Australian population?

Answer:

There is regular structured and informal dialogue between the Department of Health and Ageing and individual drug companies and the peak industry bodies, Medicines Australia and the Generics Medicines Industry Association. A key component of these discussions concerns ensuring that all Australians have timely access to safe, effective and cost effective medicines.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-059

OUTCOME 2: Access to Pharmaceutical Services

Topic: ONCOLOGY DRUG BUDGET

Written Question on Notice

Senator Abetz asked:

Why does the government continue to fund simple OTC remedies that could save the government enough monies to double the oncology drug budget?

Answer:

The Pharmaceutical Benefits Scheme (PBS) does not subsidise over-the-counter (OTC) medicines. However, some simple medicines are listed where the Pharmaceutical Benefits Advisory Committee (PBAC) is of the view that, should these medicines be removed from the PBS, patients would be prescribed more expensive products, which may also be more potent and less suitable for the patient's condition.

A good example of this is paracetamol which is the recommended first-line treatment for osteoarthritis. Its deletion could lead to the prescribing of stronger pain-relievers which would be less suitable and more expensive.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-074

OUTCOME 2: Access to Pharmaceutical Services

Topic: FIFTH COMMUNITY PHARMACY AGREEMENT

Written Question on Notice

Senator Siewert asked:

What is the legislative backing for a Fifth Community Pharmacy Agreement?

Answer:

The *National Health Act 1953 (the Act)* in Section *98BAA(1)* sets out the requirements for 'an agreement in relation to the manner in which the Commonwealth price of all or any pharmaceutical benefits is to be ascertained for the purpose of payments to approved pharmacists in respect of the supply by them of pharmaceutical benefits'. Section 100 of the Act states that, this agreement must be between the 'Minister (acting on the Commonwealth's behalf) and the Pharmacy Guild of Australia or another pharmacists' organisation that represents a majority of approved pharmacists'.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-075

OUTCOME 2: Access to Pharmaceutical Services

Topic: APPROVED PHARMACIES

Written Question on Notice

Senator Siewert asked:

What accountability mechanisms are there for Approved Pharmacies?

Answer:

The approval of a pharmacist or a medical practitioner to supply pharmaceutical benefits is subject to conditions specified in section 92A (1) of the *National Health Act 1953*.

The conditions of approval include complying with the legal requirements for practicing pharmacy, treating patients with dignity and respect, complying with the Pharmaceutical Society of Australia's Professional Practice Standards and maintaining a disciplined dispensing procedure. It also provides that an approved pharmacist must maintain the currency of his or her pharmaceutical knowledge in accordance with the Pharmaceutical Society of Australia's Competency Standards 2003.

The legislation also provides that an approved pharmacist at particular pharmacy premises must ensure that a person who is not an approved pharmacist and who supplies pharmaceutical benefits at those premises also complies with the conditions.

Pharmacy Boards operate in each state and territory and are responsible for the practice of pharmacists and the administration of pharmacy legislation particular to the jurisdiction.

Approved pharmacists are also subject to audit and compliance measures administered by Medicare Australia, which works to ensure that the correct pharmaceutical benefits are claimed for properly rendered services, and to prevent and detect fraud and inappropriate practice with respect to claiming of benefits.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-076

OUTCOME 2: Access to Pharmaceutical Services

Topic: PHARMACIES

Written Question on Notice

Senator Siewert asked:

Does the Department believe there are too many pharmacies with money spread too thinly across too many?

Answer:

The Pharmacy Location Rules form part of the Fourth Community Pharmacy Agreement between the Commonwealth of Australia and the Pharmacy Guild of Australia. An objective of the Agreement is to maintain a stable and viable community pharmacy sector so that pharmacists can continue to provide quality pharmacy services to the Australian community. The Pharmacy Location Rules have been designed to meet this objective.

Before a pharmacist can be approved to supply Pharmaceutical Benefit Scheme medicines at particular pharmacy premises they must apply to Medicare Australia who refer the application to the Australian Community Pharmacy Authority to assess the application against the Pharmacy Location Rules. The Australian Community Pharmacy Authority can only recommend to Medicare Australia that the pharmacist can be approved if the application satisfies all the specified requirements.

The requirements specified in the Pharmacy Location Rules ensure that the location of pharmacies is based on improving access to pharmaceutical benefits and services in areas of community need.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-077

OUTCOME 2: Access to Pharmaceutical Services

Topic: PHARMACISTS

Written Question on Notice

Senator Siewert asked:

a) Why are we only paying $2.69 for remote ATSI people compared to $5.99 for mainstream dispensing?

b) Couldn't the difference of $3.30 be made available to say AMSANT to employ pharmacists to work on a regional basis in upskilling clinicians and other to be able to pass on information to the Aboriginal clients of the AHSs?

Answer:

a) Under the s100 Remote Aboriginal Health Services Program, pharmacies receive a handling fee of $2.69 for the bulk supply of medicines to approved health services. The normal Pharmaceutical Benefits Scheme dispensing fee of $6.42 does not apply to this program as functions are not equivalent to, or as intensive as, dispensing.

b) This is a decision for Government.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-078

OUTCOME 2: Access to Pharmaceutical Services

Topic: PHARMACEUTICALS IN THE NT

Written Question on Notice

Senator Siewert asked:

In the NT 693,000 items dispensed (2007-08) at $3.30 would give $2.28 million. Is this not treating ATSI people in remote places in a second class way by denying them the funds that would normally go to a pharmacist to provide information on the medicines being taken?

Answer:

Under the s100 Remote Aboriginal Health Services Program, pharmacies receive a handling fee of $2.69 for the bulk supply of medicines to approved health services. The normal PBS dispensing fee of $6.42 does not apply to this program as the functions are not equivalent to, or as intensive as, dispensing.

The s100 Remote Aboriginal Health Services Program is complemented by the s100 Pharmacy Support Allowance, which is established under the Fourth Community Pharmacy Agreement. The allowance is available to eligible pharmacists to provide a range of Quality Use of Medicines and medication management services to support remote area Aboriginal Health Services that participate in s100 Remote Aboriginal Health Services Program. The allowance ranges from $6,000 to $10,500 per annum, plus other Aboriginal Health Service Outstation and travel loadings, with expected total expenditure in 2008-09 of $2.64 million.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-138

OUTCOME 2: Access to Pharmaceutical Services

Topic: INSULIN PUMP MEASURE

Hansard Page: CA 116

Senator Barnett asked:

You had a budget of $1,068,671 for a subsidy. In total what has been expended to date this financial year? You have to pay JDRF and other costs. What is the total expenditure to date for this financial year from 1 November, when the scheme started?

Answer:

The following table provides a breakdown of the funds expended to 3 June 2009.

Breakdown	**2008-09**
JDRF Pumps – subsidies paid	$68,671
JDRF Administration	$121,000
NDSS (consumables)*	$13,252
Centrelink Administration	$115,000
Departmental Administration #	$100,936
Total	$418,859

** Estimate.*
 # This figure is pro-rata.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-139

OUTCOME 2: Access to Pharmaceutical Services

Topic: INSULIN PUMP MEASURE

Hansard Page: CA 117

Senator Barnett asked:

Do you still accept that there are 11,000 young Australians, under the age of 18, who have type 1 diabetes, with an extra 1,000 cases per year?

Answer:

According to data obtained from Diabetes Australia Ltd, there are approximately 9,436 young Australians, under the age of 18, registered with the National Diabetes Services Scheme with Type 1 Diabetes. There have been, on average, approximately 1,205 new registrations within this age group each year, over the last three years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-140

OUTCOME 2: Access to Pharmaceutical Services

Topic: CHEMOTHERAPY MEDICINES

Hansard Page: CA 119

Senator Cormann asked:

Has the Government considered approaching generic medicine manufacturers, who might be more willing to adapt their vial sizes? If not, why not?

Answer:

Generic medicine companies are unable to manufacture patented medicines, including alternate vial sizes, without the permission of the patent holder. The Department has made a number of approaches to suppliers to introduce vial sizes which align more closely with the needs of patients. The majority of these approaches have not been successful.

The Government can not compel companies to register alternate vial sizes with the Therapeutic Goods Administration, or list with the Pharmaceutical Benefits Scheme.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-141

OUTCOME 2: Access to Pharmaceutical Services

Topic: CHEMOTHERAPY MEDICINES

Hansard Page: CA 106

Senator Cormann asked:

I have been told invariably that there has not been any consultation until very recently with oncologists or patient groups or pharmacist, both from the public or private sector. You were talking to us about consultation when we met in February. Who exactly did you consult with in January-February?

Answer:

A document explaining the measure and inviting comments on aspects of the measure was sent to the following organisations on 10 February 2009.

In addition, the Department met with the following organisations in January and February 2009.

STAKEHOLDER	**DATE**
Australian Pharmaceutical Industries	10 February 2009
Australian Private Health Insurance Association	10 February 2009
Australian Private Hospitals Association	10 February 2009
Baxter Healthcare	10 February 2009
Central Hospital Supplies	10 February 2009
Clifford Hallam Healthcare	10 February 2009
Clinical Oncological Society of Australia	10 February 2009
Generics Medicines Industry Association	11 February 2009
Haematology Oncology Clinics of Australasia	10 February 2009
Medical Oncologists Group of Australia	10 February 2009
Medicines Australia	10 February 2009

National Pharmacies	11 February 2009
Pharmacy Guild of Australia	10 February 2009 & 28 January 2009
Pharmatel Fresenius Kabi	10 February 2009
Primary Healthcare	10 February 2009
Private Cancer Physicians of Australia	10 February 2009
Sigma	10 February 2009
Society of Hospital Pharmacists of Australia	10 February 2009
State Governments participating in Health Care Reforms	10 February 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-196

OUTCOME 2: Access to Pharmaceutical Services

Topic: CHEMOTHERAPY DRUGS

Written Question on Notice

Senator Adams asked:

In relation to the Intravenous Chemotherapy Supply Program, is the department aware that many cancer patients could face delays in their treatment and have access to critically important chemo drugs undermined?

Answer:

The Department has undertaken extensive stakeholder consultation, which is one of the reasons why the Minister agreed to extend the implementation date of the Intravenous Chemotherapy Supply Program. This process has confirmed that the Intravenous Chemotherapy Supply Program will not pose a threat to the continued availability and accessibility of chemotherapy medicines.

The consultation process has also confirmed that nothing in the measure will cause delays in treatment, including in relation to treatment for cancer patients living in regional and remote areas. Even in instances where provision of chemotherapy medicines through a community pharmacy is not feasible, third party reconstitution providers are able to supply completed infusions to 95 percent of Australia within 24 hours, and virtually all areas can be supplied with 48 hours. This is the case presently, and it will continue to be the case once the measure is implemented.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-197

OUTCOME 2: Access to Pharmaceutical Services

Topic: CHEMOTHERAPY MEDICINES

Written Question on Notice

Senator Adams asked:

Why has the department not recognised that wastage as part of chemotherapy medicines is an inherent part of chemotherapy supply?

Answer:

The measure will prevent unnecessary wastage of expensive chemotherapy medicines funded through the Pharmaceutical Benefits Scheme (PBS). Wastage (and unnecessary PBS expenditure) of these medicines currently occurs in two ways.

First, the PBS currently subsidises whole unused vials of chemotherapy medicines. Prescribers currently prepare one prescription for a particular chemotherapy medicine, which provides sufficient medicine to cover up to several infusions over a month or longer. Pharmacists claim all of the vials in accordance with the prescription but these may not all be used for the patient, due to reductions in dosages, changes in treatment regimes and patient death. These additional vials may be used for other patients and be the subject of a new PBS claim.

The second is through medicine remaining in vials after infusions have been prepared. While it is very difficult to achieve absolute efficiency by using 100 percent of every vial every time, it is possible to safely prepare other infusions from the open vial by using batch production techniques.

Pharmacists have acknowledged these practices currently occur and it is these areas that the measure targets.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-198

OUTCOME 2: Access to Pharmaceutical Services

Topic: CHEMOTHERAPY DRUGS

Written Question on Notice

Senator Adams asked:

a) Is the department aware of the effect on pharmacists if the government pays for only the amount of chemotherapy used? Eg, if only ¾ of a vial is used the pharmacists would be out of pocket for ¼ of a vial. Therefore a pharmacist could be out of pocket by up to $640 for a drug such as Herceptin?

b) Is the department also aware, if this continues, pharmacy sites will have to close down, supply a limited range of infusions, or only supply some drugs?

c) Is the department, in trying to reduce costs and save approximately $30 million per annum, aware that this will then impact on all aspects of chemotherapy, from specialists through to patients and their families?

Answer:

a) This measure is designed to encourage the efficient use of chemotherapy medicines. Pharmacists have acknowledged that they already prepare infusions efficiently by using medicine that is left in a vial after an infusion is prepared for another infusion. The Government intends to realise the benefits of this by paying for the amount of medicine actually used in chemotherapy infusions or injections.

   Pharmacists may choose to obtain prepared products from third party providers where they can not efficiently prepare infusions in-house. This is consistent with current arrangements.

b) This measure is designed to reduce Pharmaceutical Benefits Scheme expenditure and therefore some pharmacists may make reduced profits on chemotherapy medicines. However, pharmacists will benefit from the new infusion fee, which will apply to each infusion, rather than the current dispensing fee of $6.42 which applies to each prescription (which can cover up to 10 infusions).

   Pharmacists currently make commercial decisions about what products they make up and which they source from third parties. They will continue to make these types of decisions under the new arrangements.

c) The Government agreed to extend the implementation of this measure so that the Department could consult widely and comprehensively with members from all stakeholder groups, including the pharmaceutical industry, pharmacists, clinicians, and patient groups, to ensure that access to chemotherapy and patient safety will not be compromised. A wide range of issues were canvassed during this process of consultation, and the Government will carefully consider these to ensure that patients and prescribers are not adversely affected by this measure.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-304

OUTCOME 2: Access to Pharmaceutical Services

Topic: JUVENILE INSULIN PUMPS FOR DIABETES

Written Question on Notice

Senator Boyce asked:

a) With regards to the Type 1 Diabetes Insulin Pump Program, how many families have accessed assistance under the scheme to date?

b) Has the number of families accessing the Scheme been revised? If so, how many families are now expected to access the Scheme in the next four years?

c) Why has the uptake of the Scheme been poor, and what recommendations have been made or what action is being considered to improve access to the program?

Answer:

a) As at 3 June 2009, 108 families have submitted subsidy applications. Of the applications received, the Juvenile Diabetes Research Foundation have approved and paid 30 pump subsidies.

b) It was originally estimated that around 700 families will receive assistance under the Program over the four year period. The Department is continually monitoring the Program's implementation and uptake, however no changes to these estimates have been made.

c) The Minister for Health and Ageing has requested Departmental advice regarding the lower than anticipated uptake of the Program. It is expected that the Minister will consider advice provided to her and determine whether any changes to the program are required.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-303

OUTCOME 2: Access to Pharmaceutical Services

Topic: PBS SAVINGS

Written Question on Notice

Senator Boyce asked:

Can the Government also provide a comprehensive breakdown by cost of the contribution of the other PBS savings measures since 2007 and in the forward estimates, including but not limited to:

a) WAMTC (Weighted Average Monthly Treatment Cost);
b) 12.5 per cent;
c) Safety net 20 day rule;
d) Revision of PBS safety net thresholds; and
e) Revisions of PBS patient co-payments.

Answer:

a) **WAMTC (Weighted Average Monthly Treatment Cost)**
The savings from this ongoing administrative activity are not included in forward estimates.

b) **12.5 per cent**
The 2005-06 Budget measure *Pharmaceutical Benefits Scheme – price reduction for new brand listings* was legislated in 2006 and became part of the broader Pharmaceutical Benefits Scheme Reform legislation, implemented in 2007. Savings for the 12.5% measure cannot be identified separately as they have been subsumed into the overall savings for PBS reforms.

c) **Safety Net 20 Day Rule**
The 2005-06 Budget measure *Pharmaceutical Benefits Scheme – reinforcing safety net arrangements* commenced on 1 January 2006. Savings attributable to this measure in 2007-08 are estimated at $24.4 million. The data required to generate a 2008-09 estimate is not yet available. The forward estimate of savings for 2008-09 was $20.5 million.

d) **Revision of PBS safety net thresholds**
The 2005-06 Budget measure *Pharmaceutical Benefits Scheme – increase concessional and general safety net thresholds* commenced on 1 January 2006. Savings attributable to this measure in 2007-08 are estimated at $40.8 million. The data required to generate a

2008/09 estimate is not yet available. The forward estimate of savings for 2008-09 was $71.4 million.

e) **Revisions of PBS patient co-payments**

The 2002-03 Budget measure *Sustaining the Pharmaceutical Benefits Scheme – Realigning Patient Co-Payments* and *Safety Nets* (the measure) resulted in an increase to PBS patient co-payments and safety net thresholds on 1 January 2005 (in addition to annual indexation). The implementation delay from January 2003 to January 2005 was due to the time required for passage of legislation through the Parliament. The measure is no longer active for reporting purposes; savings have not been monitored or reported separately since 2006-07. Savings from the measure cannot be identified separately as they have now been subsumed into the overall savings from the 2006 PBS reforms. The revised estimate of savings for the measure undertaken for the PEFO 2004 (Pre-election Economic and Fiscal Outlook) was $235.0 million for 2007-08 and $234.5 million for 2008-09.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-330

OUTCOME 2: Access to Pharmaceutical Services

Topic: PBS APPROVAL

Hansard Page: CA 104

Senator Ryan asked:

Dates of PBS approval for Zostavax and flu vaccine?

Answer:

The PBAC recommended that subsidised access to influenza vaccine for persons aged between six months and 64 years at special risk of adverse consequences from infections of the lower respiratory tract be moved from the Pharmaceutical Benefits Scheme to the National Immunisation Program at its July 2008 meeting.

The Pharmaceutical Benefits Advisory Committee recommended the addition of Zostavax to the National Immunisation Program for patients aged 60 years (and a catch-up cohort of all individuals aged 61 to 79 years) at its March 2008 meeting.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO
Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-302

OUTCOME 2: Access to Pharmaceutical Services

Topic: PBS REFORM

Senator Boyce asked:

In response to Question on Notice 1360 from last Budget Estimates, the Department of Health has said that savings from PBS reform will be $103 million over four years instead of the forecast $580 million.

Can the Department please provide a comprehensive breakdown by cost of the contribution PBS reform measures have had on the projected PBS forecasts, including but not limited to:

a) The revision of savings from the ad hoc price reduction for Simvastatin;

b) F2A and F2T price cuts;

c) PBS price disclosure; and

d) Movement of some medicines prior to implementation from F2T to F2A.

Answer:

The adjustments listed below have had an impact on the savings from the PBS Reform over the period 2006-07 to 2010-11:

a) It is estimated that the reduction in PBS Reform savings due to the ad hoc price reduction for simvastatin is around $78 million over the period.
b) There have been no adjustments to the estimated savings from the 25 per cent and two per cent statutory price reductions over the period.
c) There have been no adjustments to the estimated savings from PBS Price Disclosure related price reductions over the period.
d) The estimated reduction in PBS Reform savings from the reclassification of Alendronic acid and five other medicines from F2T to F2A between 2006-07 and 2010-11 is ‘Cabinet in Confidence’ and as such will not be made publicly available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-028

OUTCOME 3: Access to Medical Services

Topic: HEALTHY KIDS CHECK

Written Question on Notice

Senator Ryan asked:

What was the cost of these health checks to Medicare under MBS Items 709 and 711?

Answer:

From 1 July 2008 up to and including 30 April 2009, the total cost to Medicare of MBS items 709 and 711 was $1,467,059.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-87

OUTCOME 3: Access to Medical Services

Topic: MSAC

Written Question on Notice

Senator Siewert asked:

Are you able to provide an update on the MSAC assessment timeframes for other indications?

Answer:

MSAC has now completed the assessment of 12 of the 22 indications recommended by MSAC in 2000 and 2001 for interim public funding pending collection of data for further evaluation.

MSAC will provide advice to the Minister by the end of 2010 on the outcomes of its assessment of the remaining ten indications for PET. The following table shows the expected timeframe for the assessment of the ten outstanding MSAC PET indications.

MSAC Reference Number / Name	**PET indication to be assessed**	**Expected Date for MSAC consideration**
35c PET for Lymphoma	Staging of newly diagnosed or previously untreated Hodgkin's or non-Hodgkin's lymphoma	September 2009
	Evaluation of residual mass after treatment of Hodgkin's or non-Hodgkin's lymphoma	
	Restaging of suspected recurrent/residual Hodgkin's or non-Hodgkin's lymphoma	
35d PET for Glioma and Sarcoma	Staging of biopsy-proven bone or soft tissue sarcoma being considered for resection of the primary or limited metastatic disease	December 2009
	The evaluation of suspected residual or recurrent sarcoma on structural imaging after definitive therapy	
	Primary staging in patients with suspected primary brain tumour	
	Evaluation of residual structural lesions after definitive therapy for recurrent glioma	
	Guiding biopsy of suspected bone or soft tissue sarcomas, where structural imaging suggests lesion heterogeneity	
35e PET for Cervical Cancer	Assessment of patients with cervical or endometrial carcinoma for staging of disease prior to planned radical radiation therapy or combined modality therapy	March 2010

35f PET for Myocardial viability	Assessment of ischaemic heart disease	June 2010

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-008

OUTCOME 3: Access to Medical Services

Topic: COSMETIC SURGERY

Written Question on Notice

Senator Ryan asked:

How many such procedures [*cosmetic/plastic surgery procedures*] have been performed and what is their total cost?

Answer:

Medicare does not fund procedures performed primarily for cosmetic reasons.

During the 2008 calendar year, 197,300 procedures were performed under items listed in the plastic and reconstructive surgery section (subgroup 13) of the MBS.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-009

OUTCOME 3: Access to Medical Services

Topic: COSMETIC SURGERY

Written Question on Notice

Senator Ryan asked:

What is the cost to the MBS [*Medicare*] of each [*cosmetic/plastic surgery*] procedure?

Answer:

Medicare does not fund procedures performed primarily for cosmetic reasons.

The total cost of all therapeutic procedures performed in the plastic and reconstructive surgery section (subgroup 13) of the MBS during the 2008 calendar year was $57 million.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-010

OUTCOME 3: Access to Medical Services

Topic: MEDICARE REBATES – COSMETIC SURGERY

Written Question on Notice

Senator Ryan asked:

a) Has the Department received any evidence or reports that Medicare rebates have been claimed for such procedures [*cosmetic/plastic surgery procedures*] contrary to these restrictions?

b) If so, what action has been taken?

Answer:

No. Any suggestion of incorrect billing against Medicare is referred to Medicare Australia for appropriate follow-up or action. Medicare Australia has provided a response to this question to the Senate Finance and Public Administration Standing Committee. Their response is numbered HS23(d).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-011

OUTCOME 3: Access to Medical Services

Topic: COSMETIC PROCEDURES

Written Question on Notice

Senator Ryan asked:

How many cosmetic [*plastic/reconstructive/therapeutic*] procedures are undertaken each year in Australia and in:

a) Victoria
b) New South Wales
c) Queensland
d) South Australia
e) Western Australia
f) Tasmania
g) ACT
h) NT

Answer:

Medicare does not fund procedures performed primarily for cosmetic reasons.

The number of Medicare-funded plastic and reconstructive procedures performed during 2008 was 197,300.

The number of these procedures performed in each State and Territory in 2008 was:

(a) New South Wales = 61,447
(b) Queensland = 55,839
(c) Victoria = 38,670
(d) South Australia = 17,109
(e) Western Australia = 16,783
(f) Australian Capital Territory = 3,428
(g) Tasmania = 3,215
(h) Northern Territory = 809

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-012

OUTCOME 3: Access to Medical Services

Topic: COSMETIC PROCEDURES

Written Question on Notice

Senator Ryan asked:

What are the ten most performed cosmetic procedures?

Answer:

Medicare does not fund procedures which are performed primarily for cosmetic reasons. Medicare funds a number of plastic and reconstructive procedures performed for medical/therapeutic reasons.

In terms of these Medicare-funded plastic and reconstructive procedures, the ten most commonly performed during 2008 were (in descending order):

1. Item 45200 (skin flap procedure)
2. Item 45206 (skin flap procedure)
3. Item 45451 (skin graft procedure)
4. Item 45203 (skin flap procedure)
5. Item 45520 (breast reduction procedure)
6. Item 45617 (eyelid reduction procedure when skin obscures vision)
7. Item 45665 (wedge excision of lips, eyelids or ears)
8. Item 45003 (skin flap procedure)
9. Item 45506 (facial/neck scar revision procedure)
10. Item 45626 (correction of eyelid which turns inwards or outwards)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-026

OUTCOME 3: Access to Medical Services

Topic: HEALTHY KIDS CHECK

Written Question on Notice

Senator Ryan asked:

How many 'Healthy Kids Checks' have been conducted since their release on 1 July 2008?

Answer:

From 1 July 2008 up to and including 30 April 2009, 32,072 Healthy Kids Check Medicare Benefits Schedule (MBS) services have been conducted.

In addition from 1 July 2007 to 17 October 2008, 12,263 Child Health Checks were performed through the Northern Territory Emergency Response and Medicare Benefits Scheme (MBS) Item 708. These figures represent the latest data available from the December 2008 report, *Progress of the Northern Territory Emergency Response Child Health Check Initiative.*

The Healthy Kids Check complements child health assessment services provided by State and Territory governments and are not intended to compete with existing State and Territory early childhood services. A total amount of $7.4 million over 4 years has been provided to all States and Territories to promote integration of the Check with their existing services. Funding agreements with all State and Territory governments are now in place.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-305

OUTCOME 3: Access to Medical Services

Topic: BLOOD TESTING ON PREGNANCIES

Written Question on Notice

Senator Boyce asked:

a) With reference to standard blood testing for pregnant women and mothers in relation to genetic mutations, can the Department outline what routine tests are undertaken when a woman presents herself for such a blood test?

b) Can the Department outline how difficult it would be to perform a test for "inherited blood clotting" when other tests are done for pregnant women?

Answer:

a) There are no routine genetic mutation tests undertaken on pregnant women. The decision to offer a test for a genetic mutation would be made on the basis each woman's individual situation eg a previous pregnancy with a genetic mutation, or a family history.

The Royal Australian and New Zealand College of Obstetricians and Gynaecologists (RANZCOG) suggests the following tests be performed at the first antenatal visit – blood group and antibody screen; full blood count; rubella antibody status; serology for hepatitis B, hepatitis C, HIV and syphilis; and a mid stream urine (College statement – antenatal screening tests 2008).

Tests to identify pregnancies at higher risk of chromosomal anomalies such as Down's syndrome can be performed in early pregnancy. Such testing is best implemented in the context of a comprehensive program that coordinates pre-test counselling and information, biochemical and ultrasound measurements, post-test interpretation, counselling and support during decision making and, where indicated, follow-up consultations and diagnostic testing. (RANZCOG statement - Prenatal screening tests for trisomy 21 (Down syndrome), trisomy 18 (Edwards syndrome) and neural tube defects 2007).

b) A test for an "inherited clotting disorder", such as the factor V Leiden gene mutation, could be done at the same time as other routine blood testing in pregnancy.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-086

OUTCOME 3: Access to Medical Services

Topic: PET SCANNING

Written Question on Notice

Senator Siewert asked:

I understand that in August 2008 the Minister noted Medical Services Advisory Committee (MSAC) approved trials had found that PET scanning prevented 1 in 4 patients with oesophageal cancer from having surgery that was likely to do more harm than good. The Minister would have noted MSAC's prediction that PET could reduce the cost of caring for patients with oesophageal cancer, by between $821,000 to $1,539,000 per annum. When PET scanning reduces patient suffering and the cost of their care, why hasn't the government put this indication on the general Medicare Benefit Schedule (MBS)?

Answer:

On 28 August 2008, the Minister for Health and Ageing noted advice from the MSAC in relation to two different indications for oesophageal cancer. They are for:

1) the conventional staging of primary cancer of the oesophagus or the gastro-oesophageal junction (GEJ), and
2) residual oesophageal cancer following definitive chemoradiation considered suitable for salvage surgery.

MSAC advised that there was sufficient evidence to support public funding for the first indication, but not for the second.

Before a PET item can be listed on the MBS, a number of legislative and administrative processes must be completed. These include:

- consultation with clinicians to develop or amend item descriptors;
- costings agreed with the Department of Finance and Deregulation;
- need to comply with agreed processes for adding new expenditure to the MBS;
- changes to Medicare Australia's payments system;
- drafting of legislative instruments and seeking Ministerial sign off on the instrument; and

– listing of the legislative instrument on the Federal Register of Legislative Instruments.

Two new items were developed for the MBS:

- 61577 (Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy) and
- 61580 (Whole body FDG PET study, performed for the staging of proven oesophageal or GEJ carcinoma, in patients considered suitable for active therapy, with catheterisation of the bladder)

As Mr Kingdon advised on 4 June 2009, the Department had scheduled these items to be listed on the MBS for access through all eligible PET facilities from 1 July 2009. Unfortunately, a delay in finalising costings (due to factors outside the Department's control) has since required implementation of these items to be delayed.

It is now anticipated that these items will be implemented on the MBS from 1 September 2009 for all eligible PET facilities under the *Health Insurance (Positron Emission Tomography) Determination 2009.*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-088

OUTCOME 3: Access to Medical Services

Topic: PET SCANNING IN BREAST CANCER

Written Question on Notice

Senator Siewert asked:

I understand that in 1999, applications to MSAC included consideration of PET scanning in breast cancer, however, these applications were never assessed following Minister Wooldridge's intervention.

a) Will the Minister confirm that MSAC has recommenced an evaluation of PET in breast cancer?

b) Will the Minister indicate when that evaluation will be completed?

Answer:

a) In 1999, MSAC Applications 1025 and 1027 included breast cancer indications. Both these applications were considered by MSAC under Reference 2. The use of PET in breast cancer was not amongst the indications determined by the MSAC as part of Reference 2 to warrant interim funding at that stage. MSAC had reservations about the potential value of PET scanning in breast cancer management and considered that the evidence for other indications was stronger and therefore should be given priority.

   In May 2009, the MSAC Executive Committee reviewed the remaining PET indications, including PET for breast cancer. As PET is not used in the diagnosis or primary staging of breast cancer, there is limited evidence on the effectiveness of PET scanning in monitoring a patient's response to treatment. Therefore, breast cancer was not included in the indications that MSAC recommended for interim funding and no data has been collected for this indication in Australia. The MSAC Executive agreed that PET scanning for breast cancer should not be assessed by MSAC at this time.

b) The evaluation of PET for breast cancer will be undertaken if MSAC receives an application to assess PET for breast cancer along with sufficient evidence to make a case for public funding.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-089

OUTCOME 3: Access to Medical Services

Topic: PET

Written Question on Notice

Senator Siewert asked:

I understand that the PET data collection program was scheduled to gather data in the use of PET in cancer of the cervix.

a) Is it true that no data was collected?

b) What was the reason for the failure to collect data as planned?

c) Does the failure to collect data mean that interim MBS funding for PET in cancer of the cervix will be withdrawn?

d) Does the Government agree that there have been unacceptable delays in providing appropriate access for women with gynaecological cancers to PET scanning services?

Answer:

a) No. On 23 May 2001, the MSAC recommended an additional set of indications (MSAC Reference 10 [Part 2(i)]) to be included in the data collection program. These included the assessment of patients with cervical or endometrial carcinoma for staging of disease prior to planned radical radiation therapy or combined modality therapy.

b) On 3 November 2003, the MSAC PET Data Group agreed that a lack of patient numbers could not support a prospective clinical protocol development for cervical cancer. It was agreed that study sites would collect demographic/descriptive data on cervical cancer with a review of any new international literature to follow the conclusion of the data collection program.

c) No. On 21 June 2001, the then Minister for Health and Aged Care, signed Health Insurance Determination HS/2/01, a determination under section 3C of the *Health Insurance Act 1973*. This determination commenced on 1 October 2001 and enabled interim MBS funding for whole body PET study, performed for the primary staging of proven carcinoma of the uterine cervix, prior to planned radical radiation therapy or combined modality therapy (item number 61571) for six PET facilities which were successful in the PET tender process.

d) No. Cervical cancer (item number 61571) has been approved by the Minister to be funded until June 2010 and the MSAC will re-evaluate cervical cancer in 2009/10 as part of Ref 35(e).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-090

OUTCOME 3: Access to Medical Services

Topic: MSAC

Written Question on Notice

Senator Siewert asked:

One of the key frustrations I have heard from stakeholder related to the delay in the Government acting on advice from MSAC. For example, I understand that in August 2007 MSAC provided the Government with advice that PET scanning could prevent patients with recurrent bowel cancer from having surgery that was likely to do more harm than good, and that PET could reduce the cost of caring for these patients by between $6,113,000 and $10,187,000 per annum. The Minister accepted MSAC advice 19 May 2008; however the MBS was not amended to make PET scanning more widely available until February 2009. When PET scanning reduces patient suffering and the cost of their care, please explain the delay (how can the Government justify this long delay in getting this indication for PET onto the general MBS)?

Answer:

It is correct that MSAC provided its advice on colorectal cancer to the previous Government in August 2007. In October 2007 an election was called and the Government was placed in caretaker mode.

Following the Minister's noting of MSAC's advice in May 2008 a number of administrative, budgetary and legal processes were undertaken to allow a new PET item to be listed on the Medicare Benefits Schedule (MBS). The timeframe for many of these processes is outside the Department's control. These include:

- consultation with clinicians to develop or amend item descriptors;
- costings agreed with the Department of Finance and Deregulation;
- need to comply with agreed processes for adding new expenditure to the MBS;
- changes to Medicare Australia's payments system;
- drafting of legislative instruments and seeking Ministerial sign off on the instrument; and

– listing of the legislative instrument on the Federal Register of Legislative Instruments.

The Department convened a group of expert clinicians to develop appropriate item descriptors for colorectal cancer and they provided a recommendation by late August 2008. The items were placed on the MBS on 1 December 2008, not February 2009 as stated in the question.

The time from the Minister noting MSAC's recommendation to the item being made available on the MBS was approximately seven months. This is not an unreasonable timeframe in which to complete the various processes required between Ministerial noting of MSAC's recommendation and listing on the MBS.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-091

OUTCOME 3: Access to Medical Services

Topic: PET SCANNING

Written Question on Notice

Senator Siewert asked:

In August 2007, MSAC provided the Government with advice that PET scanning could prevent patients with ovarian cancer from having surgery that was likely to do more harm than good, and could reduce the cost of caring for these patients by between $168,000 and $1,961,000 per annum. The Minister accepted MSAC's advice 19 May 2008, but the MBS was not amended to make PET scanning more widely available until February 2009. When PET scanning reduces suffering and the cost of caring for patients with ovarian cancer, why was there such a long delay in getting this indication for PET onto the general MBS?

Answer:

MSAC provided its recommendations on ovarian cancer to the previous Government in August 2007. In October 2007 an election was called and the Government was placed in caretaker mode.

Following the Minister's noting of MSAC's advice in May 2008 a number of administrative, budgetary and legal processes were undertaken to allow a new PET item to be listed on the Medicare Benefits Schedule (MBS). These include:

- consultation with clinicians to develop or amend item descriptors;
- costings agreed with the Department of Finance and Deregulation;
- need to comply with agreed processes for adding new expenditure to the MBS;
- changes to Medicare Australia's payments system;
- drafting of legislative instruments and seeking Ministerial sign off on the instrument; and
- listing of the legislative instrument on the Federal Register of Legislative Instruments.

The Department convened a group of expert clinicians to develop appropriate item descriptors and they provided a recommendation by late August 2008. These items were placed on the MBS on 1 December 2008, not February 2009 as stated in the question.

The time from the Minister noting MSAC's recommendation to the item being made available on the MBS was approximately seven months which is not an unreasonable timeframe for the implementation phase.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-092

OUTCOME 3: Access to Medical Services

Topic: PET DATA COLLECTION

Written Question on Notice

Senator Siewert asked:

Another example relates to lung cancer where I understand that the Department and MSAC decided that non small cell lung carcinoma (lung cancer) need not be included in the PET data collection process in February 2001.
Is this correct?

Answer:

Non-small-cell lung carcinoma (lung cancer) was not included in the PET data collection process in February 2001. However, in 2004, MSAC agreed that public funding for PET for solitary pulmonary nodules and non-small-cell lung cancer (Reference 16) should be supported. The MSAC recommendation was endorsed by the then Minister for Health and Ageing on 2 March 2005. On 6 December 2005, this item (number 61529) was then added to the Medicare Benefits Schedule (MBS) for all eligible PET facilities, under Health Insurance (Positron Emission Tomography) Determination HS/07/05.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-094

OUTCOME 3: Access to Medical Services

Topic: PET SCAN COSTS

Written Question on Notice

Senator Siewert asked:

I have had it put to me that:

In 2007-08 the Commonwealth spent $15.8 million on PET scan services via the MBS. Much of this expenditure was likely to have been recouped by net savings from the use of PET in just 3 indications, i.e. recurrent colorectal cancer, recurrent ovarian cancer and initial evaluation of oesophageal cancer.

a) Does the Government agree with this statement – that the cost of PET scanning is able to be recouped?

b) With its current budgetary difficulties, how can the Government justify overlooking significant savings in healthcare expenditure when these savings can be made at the same time as cancer patient suffering is reduced?

Answer:

a) Not definitively. In deciding to provide funding for PET through the Medicare Benefits Schedule (MBS), the Government has accepted advice from the Medical Services Advisory Committee (MSAC) that PET is clinically effective for particular indications, including recurrent colorectal cancer, recurrent ovarian cancer and initial evaluation of oesophageal cancer, but that cost-effectiveness could not be calculated.

MSAC found that the use of PET in patients with these indications is likely to lead to savings due to the avoidance of non-beneficial operations and associated surgical complications and mortality. However, cost effectiveness was unable to be calculated because it is unclear whether using PET translates into overall health benefits. Therefore cost consequence modelling was undertaken. The cost savings for these indications over 3 months was estimated as follows:

Colorectal Cancer – in patients planned for surgery with:

- potentially resectable colorectal liver metastases - mean cost savings of $203,332 per 100 patients, and
- locoregional recurrence - mean cost savings of $464,096 per 100 patients.

Ovarian Cancer – in patients planned for surgery - mean cost savings of $313,937 per 100 patients.

Oesophageal cancer - PET is likely to be cost saving - mean cost savings of $159,351 per 100 patients.

MSAC noted that uncertainties existed around estimated costs and consequences. It was also noted that only short-term costs and consequences were modelled; it is not known how PET may influence management and health outcomes of patients with these indications in the long term. In particular, it was unclear how the avoidance of surgery might translate to health benefits for the patient in terms of quality of life. Whilst PET is potentially cost saving, there was uncertainty associated with the overall health outcomes associated with this.

The addition of these items to the MBS is estimated to be a cost to Medicare of approximately $5.2 million annually.

b) The Government funds PET services when it has considered, in the context of other Government priorities, MSAC's advice in relation to the circumstances in which public funding should be supported.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-095

OUTCOME 3: Access to Medical Services

Topic: PET SCANNING

Written Question on Notice

Senator Siewert asked:

I understand that in 2002 and 2003 the Government received reports that found PET scanning in recurrent colorectal cancer reduces patient suffering and the cost of their care. These reports were the outcome of research grants allocated by the Department following their scientific approval by the Consultative Committee for Diagnostic Imaging (CCDI).

a) Is this correct?

b) Is it also correct that the Government has failed to act on this information that correctly detailed the clinical and cost effectiveness of PET scanning in one of the most common lethal cancers in Australia?

Answer:

a) The Department of Health and Ageing funded a report by the Consultative Committee on Diagnostic Imaging (CCDI) which examined the costs and consequences of introducing positron emission tomography (PET) imaging into the treatment protocols for four common cancer indications, including colorectal cancer. The report is dated 30 June 2003.

b) No. PET services for colorectal cancer were added to the MBS on 1 December 2008 for all eligible PET facilities under the *Health Insurance (Positron Emission Tomography) Determination 2009*.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-193

OUTCOME 3: Medicare Services

Topic: MEDICARE TEEN DENTAL PLAN

Hansard Page: CA 128

Senator Siewert asked:

By state, how many services have been provided under the Medicare Teen Dental Plan?

Answer:

The number of services that have been provided under the Medicare Teen Dental Plan from 1 July 2008 to 31 May 2009, by state, is set out below:

• **State**	• **No. of services**
• NSW	• 159,944
• VIC	• 127,511
• QLD	• 83,306
• SA	• 19,633
• WA	• 25,703
• TAS	• 5,818
• ACT	• 4,687
• NT	• 1,347
• Total	• 427,949

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-194

OUTCOME 3: Medicare Services

Topic: MEDICARE TEEN DENTAL PLAN

Hansard Page: CA 136

Senator Siewert asked:

Is it possible to provide a regional breakdown of services under the Medicare Teen Dental Plan? i.e. rural or non-metropolitan versus metropolitan.

Answer:

Generally health statistics are provided at the national or state level. To provide statistics at a smaller geographic level can lead to issues of privacy and confidentiality. Therefore, we are unable to provide this data.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-261

OUTCOME 3: Access to Medical Services

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Hansard Page: CA 123

Senator Siewert asked:

Is it possible for you to provide on notice the actual locations of PET scanner facilities that can access Medicare Benefits Schedule (MBS) items for PET?

Answer:

There are currently 19 PET scanners operating in the following 16 locations.

Liverpool Hospital, Sydney
Royal Prince Alfred Hospital, Sydney
Westmead Hospital, Sydney
Calvary Mater Newcastle Hospital, Newcastle
St Vincent's Hospital, Sydney
Peter MacCallum Cancer Centre, Melbourne
MIA Victoria, Moorabbin Radiology, Monash Medicare Centre, Melbourne
Mater Private Hospital (Lake Imaging), Ballarat
The Alfred Hospital, Melbourne
Austin Health, Melbourne
Sir Charles Gairdner Hospital, Perth
Wesley Hospital, Brisbane
Mater Private Hospital (Queensland X-Ray), Brisbane
Royal Brisbane and Women's Hospital, Brisbane
Royal Adelaide Hospital, Adelaide
Royal Hobart Hospital (MIA Tasmania), Hobart

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-262

OUTCOME 3: Access to Medical Services

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Hansard Page: CA 124-125

Senator Barnett asked:

What is the estimated total cost of installing a PET scanner at the Royal Hobart Hospital?

Answer:

The cost of setting up a PET facility would vary depending on what capital works and infrastructure changes are needed and what kind of equipment is purchased.

Advice on the cost of installing a PET scanner at the Royal Hobart Hospital has not yet been provided by the Tasmanian Department of Health and Human Services.

The Australian Government has undertaken to contribute $3.5 million towards the establishment of a PET facility at the Royal Hobart Hospital.

THE HON NICOLA ROXON MP
MINISTER FOR HEALTH AND AGEING

Senator Claire Moore
Chair
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2600

Dear Senator Moore Claire

At the Budget Estimates hearing of 4 June 2009, Senator Guy Barnett requested the release of the recommended provider, the final report and the recommendation in relation to the Invitation to Apply (ITA) process for the provision of a Medicare-eligible Magnetic Resonance Imaging (MRI) unit in north-west Tasmania.

The Secretary of the Department of Health and Ageing indicated that the Department would ask me whether I wished to invoke the public interest immunity test in respect of the requested information on the grounds that it is commercial-in-confidence.

The Department has briefed me about the content of the report sought by Senator Barnett. The report contains commercially sensitive material which could cause commercial harm if released as the formal assessment of applicants includes a financial assessment undertaken by the Department's financial adviser that may include findings in relation to an applicant which could prejudice their financial standing and reputation. In addition, the release of the assessment analysis of the applicants' approaches in addressing the advertised criteria would expose information about their strengths and weaknesses that could advantage their competitors in future government funding or procurement processes. I therefore consider that on balance, the need to protect these commercial interests outweighs the interests of accountability, and that release of the report is therefore not appropriate.

I am prepared to release the identity of the recommended provider in relation to this ITA process. Release of this information at this time will not cause commercial harm. This information is contained in the attached document, which also provides a summary of the ITA process and the Evaluation Committee's recommendation. This summary provides an explanation of the ITA process without a risk of commercial harm. I trust the Committee finds it helpful.

Yours sincerely

NICOLA ROXON

17 AUG 2009

NORTH-WEST TASMANIA MAGNETIC RESONANCE IMAGING (MRI) INVITATION TO APPLY (ITA) PROCESS

ITA 021/0708 for the provision of Medicare-eligible MRI service in north-west Tasmania was released in August 2007.

The ITA document was publicly available for potential applicants on the website of the Department of Health and Ageing.

The ITA document indicated that the Australian Government wished to extend eligibility for Medicare benefits to an MRI unit in north-west Tasmania, and invited applications from parties capable of establishing and operating such an MRI service.

The ITA document outlined the procedure and criteria which the Department would follow in evaluating the applications received, in particular:

- Four measured criteria were used in the evaluation– (i) proposed pricing structure/patient charging policy; (ii) hours of operation, emergency services and after-hours availability; (iii) patient accessibility; and (iv) overall assessment to determine ability to provide an ongoing Medicare benefits eligible MRI service and timeframe to become operational, including the extent to which the business plan submitted demonstrated a likelihood of achieving the ITA objectives;
- The objectives of the ITA were to (a) improve patient access to Medicare benefits eligible MRI services in north-west Tasmania; (b) ensure that the MRI services provided are of a high quality; and (c) minimise out-of-pocket expenses to patients; and
- The Department could terminate the ITA in certain circumstances, including if termination was in the public interest, or if no application represented value for money in meeting the objectives of the ITA ('value for money' was defined as "the overall capacity of applicants to effectively provide an ongoing Medicare-eligible MRI service in conjunction with a medical practice or radiology department of a hospital that offers a comprehensive range of diagnostic imaging procedures, with minimal or no out-of-pocket costs to patients").

The north-west Tasmania ITA application evaluation process was conducted by a Departmental Evaluation Committee.

There was no involvement in the evaluation process by the Minister for Health and Ageing, or her office.

Following the completion of the application evaluation process, the Evaluation Committee recommended an application from Regional Imaging Pty Ltd (RIL) as the preferred application to the Departmental delegate, but noted that a number of issues needed to be satisfactorily negotiated with RIL in order for that application to be confirmed as the successful application. The delegate approved this recommendation, and negotiations commenced with RIL.

At the conclusion of these negotiations, RIL indicated that it had extensively reviewed the business case for the north-west Tasmania MRI service, taking into consideration the commencement from July 2008 of a Medicare-eligible MRI service at Launceston General Hospital. As a result, the preferred applicant indicated that it was unable to commit to provide a service in north-west Tasmania under the requirements of the ITA document.

There was no suitable alternative north-west Tasmania application which was able to be considered as an alternative preferred application.

Following the announcement in the 2009 Budget that the north-west Tasmania ITA would not be proceeding, with the Government instead funding a package of alternative projects to improve health services in the north-west of Tasmania, the Department wrote to RIL indicating that the ITA had been terminated in the public interest. These alternate projects will involve development of an electronic clinical information and communications system, improved cancer services in north-west Tasmania and dedicated patient accommodation and expanded radiation oncology services at Launceston General Hospital.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-264

OUTCOME 3: Access to Medical Services

Topic: COMMITMENT OF FUNDS FOR A LINEAR ACCELERATOR AT LAUNCESTON HOSPITAL.

Hansard Page: CA126

Senator Barnett asked:

Was there an announcement made by the Minister or any other member of the Government, in and around the time of the most recent Budget, relating to the commitment of $7.7 million for a linear accelerator at Launceston Hospital?

Answer:

Yes. A joint press release by the Minister for Health and Ageing, the Hon Nicola Roxon MP, and Jodie Campbell, Member for Bass, was released on 13 May 2009. (Attachment A)

THE HON NICOLA ROXON MP

Minister for Health and Ageing

JODIE CAMPBELL MP
Member for Bass

HEALTH SERVICES IN BASS A BIG BUDGET WINNER AND NEW PATIENT SERVICES FOR LAUNCESTON HOSPITAL

The Rudd Government will provide $40 million over three years, starting in 2008-09, to create an Acute Medical and Surgical Service Unit at Launceston General Hospital.

Under the 2009-10 Budget movement of patients between acute and emergency services at Launceston General Hospital will be significantly improved.

The Minister for Health and Ageing said that this will tackle deficiencies in current infrastructure by developing a Medical Assessment Unit, redeveloping the Day Procedures Unit, expanding the operating suite and upgrading the intensive care unit and allied health services. It will also assist the hospital in meeting safety and quality standards.

Ms Roxon said, “This project is supported under the Government's nation-building Health and Hospitals Fund, which is building health infrastructure for the 21st century, while also creating employment opportunities.”

Member for Bass, Jodi Campbell said people living in Northern Tasmania will benefit as Launceston General Hospital is the major public acute care facility in the north of the State. The new high-amenity facilities will also encourage the retention of existing staff at the hospital.

Ms Campbell said, “This investment is a major show of faith in the Launceston General Hospital and a boost for local employment in the construction industry. This project is expected to begin in 2009.”

Other Budget initiatives will see $1 million for additional patient accommodation services at Launceston Hospital’s WP Holman Clinic, $7.7 million for additional radiation oncology services at Launceston Hospital to fulfill an election commitment, and $500,000 to construct a new primary care centre to improve access to health services for people in Scottsdale.

The 2009-10 Budget also delivers a $134.4 million landmark package of measures to tackle shortages of doctors and health workers in rural and remote communities in Australia.

The reform package introduces incentives based on the principle of 'the more remote you go, the greater the reward' to encourage doctors to work in some of Australia's most isolated rural and remote communities, and will encourage doctors to go and work in rural and remote communities – and to help keep them there.

Ms Campbell said, "These benefits will be seen because the Rudd Government's Office of Rural Health looked into how rural and regional programs could best benefit those in our community most in need."

Media contact: Minister’s Office 02 6277 7220

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-007

OUTCOME 3: Access to Medical Services

Topic: COSMETIC SURGERY

Written Question on Notice

Senator Scott Ryan asked:

Which cosmetic/plastic surgery procedures can be claimed under the Medicare Benefits Schedule (MBS) and under what circumstances?

Answer:

Medicare benefits are not payable for surgical procedures performed primarily for cosmetic reasons; that is, surgery undertaken simply to improve physical appearance. However, benefits are payable for certain plastic and reconstructive surgical procedures when performed for specific medical reasons, such as breast reconstruction following mastectomy or nose surgery (rhinoplasty) following facial trauma.

Plastic and reconstructive surgical items are contained in subgroup 13 of the therapeutic procedures section of the MBS. Descriptors, fees and explanatory notes for items 45000 to 45996 are attached.

Note: the attachment was tabled in the Senate on 20.08.09 and has not been included in the electronic/printed volume

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-221

OUTCOME 3: Access to Medical Services

Topic: CATARACT SURGERY

Written Question on Notice

Senator Adams asked:

a) What is the age profile of patients who claimed these services in the last 12 months?
b) Is there any reason to expect this age profile to change in the immediate future?

Answer:

a) Medicare services processed from June 2008 to May 2009 for item 42702.
Item 42702 – lens extraction and insertion of artificial lens, excluding surgery performed for the correction of refractive error *except for anisometropia greater than 3 dioptres following the removal of cataract in the first eye* (Anaes.)

	Total
Age	
0-14	16
15-24	89
25-34	241
35-44	875
45-54	5,204
55-64	19,681
65-74	43,958
75-84	51,998
>=85	9,772
Total	131,834

Source: based on Medicare Australia's web statistics (https://www.medicareaustralia.gov.au/statistics/mbs_item.shtml)

b) There is no reason to expect this age profile to change in the immediate future as data trends have remained static over the years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-225

OUTCOME 3: Access to Medical Services

Topic: CATARACT SURGERY

Written Question on Notice

Senator Adams asked:

Can you explain the reasoning behind the perception that cataract surgery is a 'simple' procedure, based on the fact that a surgeon is coordinating two hands, two feet and inserting instruments through 2-2.5mm wounds while simultaneously manipulating tissue of 0.55mm thick, while the patient remains awake?

Answer:

The Department does not view the procedure of cataract extraction as 'simple'. The Medicare fees for cataract items have been reduced as a result of improved technology and reduction in the average surgical time required to perform the procedure. The fees for the cataract items were determined at a time when the procedure took longer and was more skill intensive. Over the years, improvements in technology, such as intraocular lenses and phacoemulsification machines, and a strong growth in cataract surgery have improved the techniques and equipment associated with performing these services.

When the surgery was first performed, the procedure would take approximately 45 minutes, but now typically takes 15 – 20 minutes. The Fred Hollows Foundation states that cataracts can be removed in a straightforward 20 minute operation, done under local anaesthetic[1]. Similarly, the Australian Institute of Eye Surgery indicates that cataract surgery usually lasts less than 20 minutes, and is often performed using anaesthetic eye drops without the need for injections[2].

International data mirrors the reduced time and complexity of cataract operations. In an article published in the British Journal of Ophthalmology, Assistant Professor Tien Yin Wong states that with the remarkable improvement in cataract surgical techniques in recent years - leading to shorter operating time (most surgery now takes 15 minutes), more efficient

1 The Fred Hollows Foundation. Information sheet: *Cataract Blindness.* Accessed from http://www.hollows.org.au/Assets/Files/Info-schools-Cataract%20blindness.pdf

2 Australian Institute of Eye Surgery. *Eye Conditions: Cataracts.* Accessed from www.aies.com.au/inside/eye_cat.html

anaesthesia (from general to regional to topical), and a trend towards day surgery - cataract extraction has become a "minor" surgical procedure[3].

3 Wong, Tien Yin (2001). 'Effect of increasing age on cataract surgery outcomes in very elderly patients', in the *British Medical Journal*. Accessed from http://www.bmj.com/cgi/content/short/322/7294/1104

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-259

OUTCOME 3: Access to Medical Services

Topic: CATARACTS

Hansard Page: CA 122

Senator Barnett asked:

Where are the bulk of cataract services delivered? Particularly for south-west Western Australia, in terms of Opthamologists. I would like to know where they are?

Answer:

In Western Australia, 57 ophthalmologists provided services reimbursed through Medicare in 2007-08. Of these, 48 provided services in major city locations and 14 provided services in locations other than a major city. Note that providers can be active in more than one area and therefore be counted in more than one location. The total number of providers will not necessarily be the sum of the providers active in each area.

Smaller and/or more sparsely populated geographic areas reduce the number of persons to which the data relates, and therefore increase revealing personal information. Without evidence substantiating that disclosure is necessary in the public interest, the Department does not release information derived from Medicare data that potentially would identify an individual patient, provider or facility.

The attached data indicates where the service was provided rather than the patient's recorded address, for example, patients may have travelled from a remote region in NSW to an inner regional area in Victoria to receive a service.

Medicare Item 42702 processed by Ophthalmologists* in Financial Year 2007/08

Providers**	Remoteness Area***		
State	0:Major City	1: Other	Total**
1:NSW	212	65	256
2:VIC	145	35	157
3:QLD	90	46	119
4:SA	41	9	46
5:WA	48	14	57
6:TAS		15	15
7:NT		3	3
8:ACT	12		12
*Total***	*545*	*181*	*646*

Services	Remoteness Area***		
State	0:Major City	1: Other	Total
1:NSW	30,939	8,845	39,784
2:VIC	23,572	4,669	28,241
3:QLD	19,472	10,514	29,986
4:SA	8,079	777	8,856
5:WA	8,476	879	9,355
6:TAS		4,667	4,667
7:NT		323	323
8:ACT	2,319		2,319
Total	*92,857*	*30,674*	*123,531*

* *Derived specialty code of 054 in June Qtr 2008*

** *Providers may be active in more than one state & area; data aggregated based on provider practice postcode.*

*** *Australian Standard Geographical Classification 2006 - Remoteness Area Classification (ABS)*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-260

OUTCOME 3: Access to Medical Services

Topic: CATARACTS

Hansard Page: CA 122

Senator Barnett asked:

What proportion of cataract services are provided to people over the age of 65?

Answer:

Approximately 80% of cataract services reimbursed through the Medicare Benefits Schedule are performed on people 65 years of age and older (June 2008 to May 2009 data).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-333

OUTCOME 3: Access to Medical Services

Topic: OBSTETRICS

Hansard Page: CA 123

Senator Siewert asked:

Were consumer groups consulted around changes to obstetrics measures and any other measures?

Answer:

The Department has had an ongoing dialogue with the Australian Medical Association and the National Association of Specialist Obstetricians and Gynaecologists since the Extended Medicare Safety Net commenced in 2004. In addition, a range of consultations were undertaken in the development of the National Maternity Services Plan.

The Department did not consult consumer groups about specific budget proposals on obstetrics.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-027

OUTCOME 3: Access to Medical Services

Topic: HEALTHY KIDS CHECK

Written Question on Notice

Senator Ryan asked:

What were the findings on each of the indicators by sex and state?

Answer:

The Minister for Health and Ageing has provided the following answer to the honourable senator's question:

The Healthy Kids Check aims to ensure every four-year old child in Australia has a basic health check to see if they are healthy, fit and ready to learn when they start school. The check promotes early detection of risk factors, delayed development and illness. It also provides an opportunity for medical practitioners and parents to discuss the child's health status and any early intervention strategies that may be required to promote healthy living.

The indicators used for the Healthy Kids Check include height, weight, eyesight and hearing assessments. These indicators are not collated as they are held in confidence by the treating medical practitioner and only shared with the patient, or in the case of a young child, with his or her parents or guardian. As is the case for all medical services, general practitioners are constrained by privacy legislation and the ethics of their own profession from divulging patient information to an unauthorised third party.

Data on the take-up of the Healthy Kids Check is collected by Medicare Australia using Medicare Benefits Schedule (MBS) claiming data. This data is collated monthly and includes information about the number of Checks undertaken per month, the gender of patients receiving the Check, and the amount paid in MBS rebates. The information is broken down by state and territory, and is publicly available on Medicare Australia's website.

Results of the Child Health Checks following the *Northern Territory Emergency Response Child Health Check Initiative* are reported in two progress reports published on the Department's website:
http://www.health.gov.au/internet/main/publishing.nsf/Content/nterchciProgressReport
http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-nt-08ProgRep

The first of these was produced in May 2008 and while it contains a smaller data set than the later report it contains the most complete breakdown of the findings of the checks as well as commentary on data quality and comparative data sources. The Child Health Check is not an MBS item.

Please note that these data are not estimates of prevalence of conditions in the population of children living in remote areas of the Northern Territory.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-093

OUTCOME 3: Access to Medical Services

Topic: PET – LUNG CANCER

Written Question on Notice

Senator Siewert asked:

I also understand that in 2004 the government sent representatives to an International Health Technology symposium in Poland, Dr Richard King and Mr John Hastings, who made it clear that PET was clinically effective in lung cancer.

a) Is this correct?

b) And is it also correct that it took until November 2006 for this indication to be added to the MBS?

Answer:

a) No. Dr Richard King and Mr John Hastings attended a symposium on International Health Technology in Poland in 2004. However, neither Dr King nor Mr Hastings presented information that indicated that PET was clinically effective in lung cancer.

b) No. On 21 June 2001, Dr Wooldridge the then Minister for Health and Aged Care, signed Health Insurance Determination HS/2/01, a determination under section 3C of the *Health Insurance Act 1973*. This determination enabled MBS funding for whole body FDG PET study, performed for the staging of proven non-small cell lung cancer, where curative surgery or radiotherapy is planned (item number 61529) for six PET facilities which were successful in the PET tender process. This item was then added to the MBS for all eligible PET facilities, under Health Insurance (Positron Emission Tomography) Determination HS/07/05 on 6 December 2005.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-014

OUTCOME 3: Access to Medical Services

Topic: COSMETIC SURGERY

Written Question on Notice

Senator Ryan asked:

Is safety data collected regarding cosmetic surgery procedures?

Answer:

The Australian Institute of Health & Welfare (AIHW) and the Department collect annual National Minimum Data Sets from States and Territories in relation to procedures performed in public hospitals. Safety related data, such as that used to measure adverse events, is collected as part of this reporting. Work is also underway as part of the new National Healthcare Agreement to report performance indicators on safety and quality in public hospitals, including as part of acute and sub-acute care settings.

Information on procedures conducted in public hospitals is also collected by State and Territory health authorities.

As cosmetic surgery procedures are not funded under the Medicare benefits arrangements, no other data is collected.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-314

OUTCOME 3: Access to Medical Services

Topic: HEPATITIS C TESTING

Written Question on Notice

Senator Heffernan asked:

a) Can the Department provide information as to the cost to the Australian healthcare system of hepatitis C virus testing?
b) If so, what is the cost of that testing between January 1990 and December 2008?
c) Also identify those tests, the organisations which have been contracted to provide those tests and how much they have each received during this time for the provision of those tests?
d) Were any of the said tests manufactured in Australia?

Answer:

a) The Department cannot provide information as to the total cost to the Australian healthcare system as cost information for hepatitis C virus testing is recorded in three different environments:
   - by the Commonwealth through Medicare;
   - by states and territories through their public hospital pathology system; and
   - by the Australian Red Cross Society.

b) The Department is not able to supply any cost information for testing of hepatitis C virus in relation to the public hospital pathology system or the Australian Red Cross Society. For Medicare, there are currently eight Medicare Benefits Schedule (MBS) items that have progressively come onto the MBS since July 1998 that specifically relate to the testing of hepatitis C virus. The total cost for these items to December 2008 is $26,348,276.

   There are a further five MBS items that test for hepatitis A or B or C, and a further three MBS items that test for a broad range of infections which may include testing for hepatitis C virus. It is not possible to separate out the cost in these items for hepatitis C only.

c) MBS items that test for the hepatitis C virus are listed in Attachment A. These tests are undertaken by independent commercial organisations that are approved pathology

practitioners, however the MBS items do not specify or stipulate the particular test that is to be used.

The Department does not hold any information relating to the tests undertaken by the public hospital pathology system or the Australian Red Cross Society.

d) There are no Australian manufacturers of commercial In-Vitro Diagnostic Devices (IVDs) that have IVDs for the detection of hepatitis C virus infection included in the Australian Register of Therapeutic Goods. Some Australian laboratories may use in-house tests for the diagnosis and/or monitoring of hepatitis C infections.

Attachment A

MBS Item Number	Item Description
69445	Detection of Hepatitis C Viral RNA in a Patient Undertaking Antiviral Therapy for Chronic Hcv Hepatitis (Including a Service Described in Item 69499) - 1 Test. to a Maximum of 4 of This Item in a 12 Month Period (Item is Subject to Rule 25). This Item has been in use since 1 November 2000.
69451	This test is the same as MBS Item 69445. It is used by an approved pathology practitioner that has received the request from another provider. The item was introduced to cater for increased testing.
69488	Quantitation of Hcv RNA Load in Plasma or Serum in the Pretreatment Evaluation or the Assessment of Efficacy of Antiviral Therapy of a Patient With Chronic Hcv Hepatitis - Where Any Request for the Test is Made by or On the Advice of the Specialist or Consultant Physician Who Manages the Treatment of the Patient With Chronic Hcv Hepatitis (Including a Service in Item 69499 or 69445) (Item is Subject to Rule 18 and 25). This Item has been in use since 1 November 2000.
69489	This test is the same as MBS Item 69488. It is used by an approved pathology practitioner that has received the request from another provider. The item was introduced to cater for increased testing.
69491	Nucleic Acid Amplification and Determination of Hepatitis C Virus (Hcv) Genotype If: (A) the Patient is Hcv RNA Positive and is Being Evaluated for Antiviral Therapy of Chronic Hcv Hepatitis; and (B) the Request for the Test is Made by, or On the Advice of, the Specialist or Consultant Physician Managing the Treatment of the Patient; to a Maximum of 1 of This Item in a 12 Month Period. This Item has been in use since 1 November 2000.
69492	This test is the same as MBS Item 69491. It is used by an approved pathology practitioner that has received the request from another provider. The item was introduced to cater for increased testing.
69499	Detection of Hepatitis C Viral RNA If at Least 1 of the Following Criteria is Satisfied: (A) the Patient is Hepatitis C Seropositive; (B) the Patient's Serological Status is Uncertain After Testing; (C) the Test is Performed for the Purpose of: (I) Determining the Hepatitis C Status of An Immunosuppressed or Immunocompromised Patient; or (II) the Detection of Acute Hepatitis C Prior to Seroconversion Where Considered Necessary for the Clinical Management of the Patient; to a Maximum of 1 of This Item in a 12 Month Period (Item is Subject to Rule 19 and 25). This Item has been in use since 1 July 1998.
69500	This test is the same as MBS Item 69499. It is used by an approved pathology practitioner that has received the request from another provider. The item was introduced to cater for increased testing.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-030

OUTCOME 3: Access to Medical Services

Topic: LAPAROSCOPIC GASTRIC BANDING

Written Question on Notice

Senator Ryan asked:

a) What is the Commonwealth Government's total financial contribution to these (laparoscopic gastric banding) procedures?
b) What is the average financial contribution by the Commonwealth to each procedure?

Answer:

a and b)

The surgical treatment of obesity, bariatric surgery, can be undertaken using several methods, of which gastric banding (also known as lap banding) surgery is one type.

In regard to Medicare-funded gastric banding surgery, there are currently a number of procedures associated with gastric banding that attract Medicare benefits, either performed laparoscopically or by open surgery, when the procedure is performed on people who are considered to be morbidly obese, and who elect to be treated as a private patient.

The Schedule fee for items 30511 and 30512 which provide for gastric banding and gastric bypass surgery are as follows:

Item 30511 – Morbid obesity, gastric reduction or gastroplasty for, by any method
Fee: $784.85 Benefit: 75% = $588.65

Item 30512 – Morbid obesity, gastric bypass for, by any method including anastomosis
Fee: $965.80 Benefit: 75% = $724.35

For in-hospital services provided to private patients, Medicare benefits are paid at 75% of the Medicare Benefits Schedule (MBS) fee.

Medicare does not cover the cost of the gastric band itself, as the Medicare benefits arrangements were designed to subsidise the cost of medical services provided by qualified medical practitioners, not the products used in conjunction with those services. Some private health funds provide benefits for aids and appliances, such as gastric bands, but the funds are free to determine the nature of health related goods that attract benefits and any restrictions or limitations on such benefits.

Medicare claiming data shows that for the 2007 and 2008 calendar years, the number of services claimed and benefits paid are as follows:

2007 calendar year	**Services (No.)**	**Benefits ($)**
MBS item 30511	9,354	4,806,429
MBS item 30512	223	142,973

Source: Medicare Australia online statistics (accessed from medicareaustralia.gov.au)

2008 calendar year	**Services (No.)**	**Benefits ($)**
MBS item 30511	13,576	6,989,928
MBS item 30512	211	135,507

Source: Medicare Australia online statistics (accessed from medicareaustralia.gov.au)

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-103

OUTCOME 3: Access to Medical Services

Topic: OBSTETRICS MBS ITEMS

Written Question on Notice

Senator Nash asked:

Does the Department expect that the increases in payments for obstetrics MBS items will flow on the rural GP obstetricians who are paid by State Governments for services provided in rural public hospitals?

Answer:

From 1 January 2010 the increase in Medicare rebates for 15 obstetrics services will apply Australia wide where these services are provided to a private patient by an eligible medical practitioner. Most rural GP obstetricians provide obstetric services under Medicare.

Services provided to a public patient in a public hospital are the responsibility of state and territory governments under the National Health Care Agreements. A salaried visiting medical practitioner working in a public hospital is not eligible to lodge a claim with Medicare for a service provided to a public patient.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-266

OUTCOME 3: Access to Medical Services

Topic: W P HOLMAN CLINIC

Hansard Page: CA 127

Senator Barnett asked:

a) Were the funds provided for patient accommodation in accordance with the amount requested?
b) How much did they request? I understand that it was a larger number – what was the number?

Answer:

a) Funds being provided by the Commonwealth for patient accommodation are a contribution towards the expansion of family style facilities.

b) There was no specific amount requested by either the W P Holman Clinic or the Tasmanian Government.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-223

OUTCOME 3: Access to Medical Services

Topic: CATARACT SURGERY

Written Question on Notice

Senator Adams asked:

What are the likely financial and health implications for the large number of Australian patients who will be impacted by the MBS fee reduction for cataract procedures?

Answer:

It is not possible to predict the financial impact on patients as a result of the amendment to the MBS fee for cataract surgery because we cannot predict the charging behaviour of doctors or whether private health insurance funds will cover any increased payment gaps. Some patients may incur an increase in out of pocket costs if doctors do not revise their fees in line with the reduction to the cataract fees.

Under the current Medicare benefits arrangements, doctors are free to determine the fee for the services they provide, and would vary on an individual basis. For a patient with private health cover, 100% of the Medicare Benefits Schedule (MBS) fee is payable; Medicare pays 75% and private health insurers pay 25%. In addition, for patients covered under the 'known or no-gap arrangements', additional benefits are payable by the private health insurer, however, this would vary depending on the provider performing the service, the type of insurance cover held by the patient, and the arrangement between the insurer and the doctor.

Cataract procedures may be performed both in and out-of-hospital. For procedures performed in-hospital, additional costs are incurred for components such as theatre, ancillary and bed fees. These costs may also be incurred for procedures undertaken out-of-hospital. As outlined above the cost of an operation in-hospital and out-of-hospital would vary on an individual basis. However, in respect to in-hospital procedures, in addition to the MBS rebate, an average of $1,700 per service is also provided through private health insurance rebates to cover the cost of the accommodation, theatre, lens and ancillary fees.

Patients who elect to be treated as a public patient receive free treatment and are not required to pay any monies for the service provided.

Patients who require a more complex cataract procedure will benefit from the introduction of a new item with a fee approximate to the current fee for item 42702 (around $831.60 – includes approximate indexation), to be developed in consultation with the profession. This recognises that some cataract procedures are more complex and time consuming.

Various media reports have outlined that some ophthalmologists will cease to service patients in rural and remote areas, following the fee reductions. However, given that the majority of services are undertaken in capital cities, metropolitan and large rural centres, the impact of the fee reduction is expected to be minimal for rural and remote patients. Assistance in treating patients in these areas is provided outside of the MBS, through programs such as the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme. Additionally, many ophthalmologists travelling to rural and remote areas receive further financial assistance from the state and territory governments which covers travel and accommodation costs, and loss of earnings at the practitioner's normal practice location.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-224

OUTCOME 3: Access to Medical Services

Topic: CATARACT SURGERY

Written Question on Notice

Senator Adams asked:

a) Can you explain this rationale: a saving of $300 by reducing the Medicare benefits for cataract surgery will result in a $3,000 increase in cost to the taxpayer with patients transferring to the public system. Would you agree that this is basically false economy?
b) Could you also explain the rationale of similar microsurgical procedures being rebated at much greater amounts? e.g. Intervertebral disc or discs $885.05.
c) What is the department doing regarding concerns that due to the reduction of the rebate for cataract surgery to $300, this is going to greatly affect rural patients?

Answer:

a) It cannot be assumed that all patients will elect to be treated as a public patient once the Medicare fees for cataracts procedures are reduced. Further, the costs associated with treating a private and public patient are not comparable; Medicare subsidises the professional component of a service rendered to a private patient, whilst all costs associated with treating a public patient, including accommodation, theatre and ancillary fees are provided free of charge to the patient.

   In respect to in-hospital procedures provided to private patients, in addition to the MBS rebate, an average of $1,700 is also provided through private health insurance rebates to cover the cost of the accommodation, theatre, lens and ancillary fees.

   Subject to an individual's private health insurance coverage, doctors' billing practices and the arrangements between doctors and insurers, some patients will not be affected by the changes, whilst some will face increased charges. Patients treated under ‘no gap arrangements’ may continue to avoid out-of-pocket expenses, as private health insurers may either provide an increased rebate, or continue contractual arrangements with practitioners to provide the service for a specified proportion above the Medicare fee.

   Patients who elect to be treated as a public patient receive free treatment and are not required to pay any monies for the service provided.

b) The Medicare fee is determined with regard to the time involved in performing the service, and the complexity and professional difficulty involved. Whilst the surgical technique used may be a good comparator, time must also be considered for the MBS fee, not just the technique used. In respect to the cited surgical procedure of partial or total discectomy of intervertebral disc/s, medical advice indicates that this procedure takes on average one hour to undertake. In contrast, cataract surgery now typically takes 15 – 20 minutes.

c) Various media reports have outlined that some ophthalmologists will cease to service patients in rural and remote areas, following the fee reductions. The majority of services are undertaken in capital cities, metropolitan and large rural centres. The Government and the Department are committed to ensuring these services continue in rural and remote areas.

Assistance is currently provided to improve access to eye services for people living in remote and rural communities through the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme. Additionally, many ophthalmologists travelling to rural and remote areas receive further financial assistance from the state and territory governments which covers travel and accommodation costs, and loss of earnings at the practitioner's normal practice location.

On 26 February 2009 the Prime Minister announced new funding of $58.3 million over four years to expand eye and ear health services for Indigenous Australians. This will provide additional services in the management of eye and ear problems that will lead to better education and employment outcomes and assist in closing the gap. This measure includes:

- expansion of the Visiting Optometrist Scheme;
- increased services to address trachoma;
- training of health workers for hearing screening;
- maintenance and purchase of medical equipment for hearing screening;
- additional ear and eye surgery, particularly for remote Indigenous clients; and
- hearing health promotion.

Also, in respect to Indigenous patients, funds under the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcome* measure allows the Australian Government to continue to invest in three further intensive surgery weeks per year in Central Australia, for the next four years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-258

OUTCOME 3: Access to Medical Services

Topic: CATARACTS

Hansard Page: CA 122

Senator Barnett asked:

What will the impact be on rural and remote Australians as a result of the rebate reduction to cataract surgery?

Answer:

It is not possible to predict the financial impact on patients as a result of the amendment to the MBS fee for cataract surgery because we cannot predict the charging behaviour of doctors or whether private health insurance funds will cover any increased payment gaps. Some patients may incur an increase in out of pocket costs if doctors do not revise their fees in line with the reduction to the cataract fees.

Under the current Medicare benefits arrangements, doctors are free to determine the fee for the services they provide, and would vary on an individual basis. For a patient with private health cover, 100% of the Medicare Benefits Schedule (MBS) fee is payable; Medicare pays 75% and private health insurers pay 25%. In addition, for patients covered under the 'known or no-gap arrangements', additional benefits are payable by the private health insurer, however, this would vary depending on the provider performing the service, the type of insurance cover held by the patient, and the arrangement between the insurer and the doctor. Cataract procedures may be performed both in and out-of-hospital. For procedures performed in-hospital, additional costs are incurred for components such as theatre, ancillary and bed fees. These costs may also be incurred for procedures undertaken out-of-hospital. As outlined above the cost of an operation in-hospital and out-of-hospital would vary on an individual basis. However, in respect to in-hospital procedures, in addition to the MBS rebate, an average of $1,700 per service is also provided through private health insurance rebates to cover the cost of the accommodation, theatre, lens and ancillary fees.

Patients who elect to be treated as a public patient receive free treatment and are not required to pay any monies for the service provided.

Patients who require a more complex cataract procedure will benefit from the introduction of a new item with a fee approximate to the current fee for item 42702 (around $831.60 – includes approximate indexation), to be developed in consultation with the profession. This recognises that some cataract procedures are more complex and time consuming.

Various media reports have outlined that some ophthalmologists will cease to service patients in rural and remote areas, following the fee reductions. Assistance is currently provided to improve access to eye services for people living in remote and rural communities through the Medical Specialist Outreach Assistance Program and the Visiting Optometrists Scheme. Additionally, many ophthalmologists travelling to rural and remote areas receive further financial assistance from the state and territory governments.

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Also, funds under the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcome* measure allows the Australian Government to continue to invest in three further intensive surgery weeks per year in Central Australia, for the next four years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-257

OUTCOME 3: Access to Medical Services

Topic: CATARACTS

Hansard Page: CA 122

Senator Barnett asked:

What evidence is available to support the decision to cut the rebate for cataract surgery?

Answer:

The Medicare fee is determined with regard to the time involved in performing the service, and the complexity and professional difficulty involved. The fee for the cataract items were determined at a time when the procedure took longer. Over the years, improvements in technology, such as intraocular lenses and phacoemulsification machines, and a strong growth in cataract surgery have improved the techniques and equipment associated with performing these services.

When the surgery was first performed, the procedure would take approximately 45 minutes, but now typically takes 15 – 20 minutes. The Fred Hollows Foundation states that cataracts can be removed in a straightforward 20 minute operation, done under local anaesthetic[4]. Similarly, the Australian Institute of Eye Surgery indicates that cataract surgery usually lasts less than 20 minutes, and is often performed using anaesthetic eye drops without the need for injections[5].

International data mirrors the reduced time and complexity of cataract operations. In an article published in the British Journal of Ophthalmology, Assistant Professor Tien Yin Wong states that with the remarkable improvement in cataract surgical techniques in recent years - leading to shorter operating time (most surgery now takes 15 minutes), more efficient anaesthesia (from general to regional to topical), and a trend towards day surgery - cataract extraction has become a "minor" surgical procedure[6].

The advancement in the technology used to carry out cataract operations means they can now be performed faster, with better results, and are safer for patients. Currently, the cataract procedure that takes around 20 minutes has a similar fee to procedures for complex skull surgery (cranioplasty), which takes more time to perform and carries greater risk for the patient.

4 The Fred Hollows Foundation. Information sheet: *Cataract Blindness.* Accessed from http://www.hollows.org.au/Assets/Files/Info-schools-Cataract%20blindness.pdf

5 Australian Institute of Eye Surgery. *Eye Conditions: Cataracts.* Accessed from www.aies.com.au/inside/eye_cat.html

6 Wong, Tien Yin (2001). 'Effect of increasing age on cataract surgery outcomes in very elderly patients', in the *British Medical Journal*. Accessed from http://www.bmj.com/cgi/content/short/322/7294/1104

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-222

OUTCOME 3: Access to Medical Services

Topic: MBS FEE REDUCTION

Written Question on Notice

Senator Adams asked:

a) What is the rationale for the MBS fee reduction on coronary angiography items?
b) On what basis was the 20% reduction calculated?

Answer:

a) Medicare fees are determined with regard to the time involved in performing the service, and the complexity and professional difficulty involved. The fee for the most commonly performed coronary angiography procedure (item 38218 – which constitutes 73 per cent of all coronary angiography procedures) was determined at a time when the procedure took longer and was more skill intensive.

   In 2003, the Medical Services Advisory Committee[7] (MSAC) stated that there have been numerous technical developments and improvements in coronary angiography over the last five decades. Catheters have decreased in size, and high-flow injection catheters have replaced thick-walled catheters. Progress in photographic recording technology has also occurred, including developments in X-ray tube performance, and real-time image display. Finally, improvements in contrast agents (dyes) used for the procedure have seen an improvement in safety.

   Considering these developments it is reasonable that the fees for coronary angiography procedures be decreased.

b) The 20 per cent reduction reflects a more appropriate level of remuneration as a result of improved skill and technology and the reduction in risk associated with the procedure.

7 Medical Services Advisory Committee (2003). Horizon Scanning Briefing No 3, March 2003: *Diagnostic and therapeutic modalities for coronary artery disease*.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-085

OUTCOME 3: Access to Medical Services

Topic: MEDICAL SERVICES ADVISORY COMMITTEE (MSAC)

Written Question on Notice

Senator Siewert asked:

Are there any indications that the Medical Services Advisory Committee (MSAC) have approved or recommended which have not yet been put on the MBS?

Answer:

After noting MSAC's advice regarding the circumstances under which public funding for these new technologies or procedures should be supported, the Minister for Health and Ageing may authorise the Department to undertake further negotiation with the medical profession on relevant fees and descriptors for the relevant medical service(s).

The following services, for which MSAC supported public funding, are not currently listed on the Medicare Benefits Schedule (MBS):

1. 1105 Multi-slice computed tomography coronary angiography (MSCTCA) in the visualisation of coronary arteries
2. 1106 Endoscopic Argon Plasma Coagulation
3. 1113 Endovenous Laser Treatment
4. 1115 Sacral Nerve Stimulation (SNS) for urinary indications

A full costing of the impact of the proposed service on MBS outlays is required to be undertaken prior to a Government decision on listing, as well as detailed negotiation with relevant craft groups to ensure the item descriptors and fees reflect contemporary clinical practice and conform with the circumstances for which MSAC advised support.

These costing and consultation processes are progressing in relation to the services listed above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-265

OUTCOME 3: Access to Medical Services

Topic: LINEAR ACCELERATOR FOR LAUNCESTON

Hansard Page: CA127

Senator Barnett asked:

Please provide a copy of the letter that was sent to the Federal Minister for Health from the Tasmanian Minister for Health in September 2008 and a copy of the report prepared by the Tasmanian Government on the preferred siting of radiation oncology services in Launceston. If you cannot provide the letter, would at least like the report that was referred to.

Answer:

The report prepared by the Tasmanian Government cannot be provided as it has not been received.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-215

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

a) Can you explain the role and functions of the Aged Care Standards and Accreditation Agency?

The Minister is quoted as saying she has asked the agency to undertake a 'major' investigation of a home's handling of an incident. The Minister talks about the agency having commenced its 'investigation'.

b) Which of the legislated functions set out in the Aged Care Act 1997 and the Accreditation Grant Principles 1999 give the agency the authority, scope or competence to conduct an investigation?

Answer

a) The Aged Care Standards and Accreditation Agency Ltd is a company limited by guarantee with the Minister for Ageing as the sole member of the company.

The objects of the Company are set out in the company constitution. The Company's objects are to:

- Manage and carry out the accreditation process for residential aged care services in accordance with the *Aged Care Act 1997* and the Accreditation Standards set out in the *Quality of Care Principles September 2002;*
- Promote high quality residential aged care, and help industry to improve residential aged care service quality, by identifying best practices and providing information, education and training to industry;
- Assess, and strategically manage, residential aged care services working towards accreditation;
- Liaise with the Department about residential aged care services that do not comply with the Accreditation Standards set out in the *Quality of Care Principles*; and
- Pursue any other objects set out in the *Aged Care Act 1997*.

The Company is not established under the Aged Care Act 1997 as its functions are not legislated. The Agency is a body corporate appointed as the accrediting body.

b) The Aged Care Standards and Accreditation Agency Ltd (as a company) does not have legislated functions. The investigation requested by the Minister for Ageing is consistent with the objectives of the company set out in its constitution.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-071

OUTCOME 4: Aged Care and Population Ageing

Topic: NON-COMPLIANCE

Written Question on Notice

Senator Xenophon asked:

a) Does DOHA agree that listing warnings of non-compliance or complaints on the web can be misleading or cause undue concern unless contextual information is provided so that people can ascertain the nature of the warning or complaint?
b) What is being planned to mitigate any risk of misleading information being placed on the web so that consumers can be fully informed?
c) What contextual information will be provided on the website?
d) Will the web record how many warnings or complaints have been made?
e) Will the web record if and when the problem was rectified?
f) Will the aged care provider be given an online right of reply?

Answer:

a) Information being published will allow consumers to be informed of homes which have been issued with a notice of non-compliance for not meeting regulatory requirements under the *Aged Care Act 1997*. Contextual information is provided which enables notices of non-compliance to be easily distinguished from sanctions, which are imposed when there is either (a) an immediate and severe risk to the health safety or well-being of residents or (b) continued non-compliance. Information is also being provided on the particular regulatory requirements which have been breached in each case. This will thereby enable readers to establish the nature of the breach. Providers who are issued with a notice of non-compliance are encouraged to communicate with residents and their families/representatives to allay any concerns.

b) All information to be published is extracted from the one database, is quality checked by the Department's State Offices which have issued the notices of non-compliance, and is confirmed as correct by the relevant State Manager.

c) Contextual information in relation to sanctions explains why sanctions are imposed, what issues are taken into account when deciding to impose a sanction, what actions are taken to keep residents informed and what information is supplied on individual sanctions. The reasons why sanctions are moved from the "current" list to the "archived" list are also supplied. The same information is supplied in relation to notices of non-compliance and is supplemented by an explanation for the delay between issuing a notice and publishing information about it i.e. because of the statutory requirement for the approved provider to be given an opportunity to make submissions in relation to the notice.

d) No.

e) Information extracted from a notice will be transferred to the "Archived Notices of Non-Compliance" list when the approved provider has addressed the non-compliance.

f) The *Aged Care Act 1997* requires that a notice of non-compliance must include an invitation to make submissions in writing within a period specified in the notice (no more than 14 days from receipt of the notice) and requires the Secretary to consider those submissions. The Department will consider any submissions made prior to publishing any information about notices of non-compliance.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-128

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 47

Senator Cormann asked:

Can you provide us with a breakdown of the public service employment levels of the complaints investigation scheme staff?

Answer:

At 1 May 2009, there was 156 Aged Care Complaints Investigation Scheme (CIS) staff located in state and territory offices. Of these: 3% are EL2; 13% are EL1; 65% are APS6; 14% are APS5; and 5% are APS4 or below.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-135

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 50

Senator Cormann asked:

How many employees in the structural part area of the CIS are not employed as investigators?

Answer:

At 1 May 2009, there were 156 officers located in state and territory offices working in the Aged Care Complaints Investigation Scheme. Of these, approximately 8% are not investigators and are involved in administrative functions, including: system support; training and development; data management; and program support.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-137

OUTCOME 4: Aged Care and Population Ageing

Topic: WORKFORCE

Hansard Page: CA 11-12

Senator Humphries asked:

I wonder if I can get some further information provided about those measures you are referring to?

Answer:

The GP Panels
The Panels Initiative commenced in July 2004 and was expanded as part of the 2007-08 Federal Budget measure *More GP services for Aged Care Residents*. The Panels Initiative aimed to increase access to primary care services for residents of Residential Aged Care Facilities (RACFs) and to improve quality of care for residents through greater collaboration between local Divisions of General Practice, RACFs and health care providers.

A review was conducted in 2007. It found that the Initiative was successful in ensuring GPs and Divisions of General Practice were working together effectively and had improved communication between facilities, GPs and Divisions. However the Initiative did not demonstrate significant improvements in access by aged care facilities to GPs and represented only marginal value for money. Panels funding was not available to pay for direct service provision and around 40% of the Panels budget was directed into program administration.

Aged Care Access Initiative
The Aged Care Access Initiative was introduced in 2008-09. It was developed in response to the recommendations of the review of the Aged Care GP Panels Initiative which commenced in 2004.

The aim of the Aged Care Access Initiative is to improve access to primary care (GP and allied health services) for residents of aged care facilities. It has two separate components:

1. An incentive payment through the Practice Incentives Program (PIP) to encourage GPs to provide more services in RACFs. The GP Aged Care Access Incentive recognises some of the difficulties faced by GPs in providing care in these settings and aims to encourage GPs to continue to provide increased and continuing services in RACFs. The PIP payments are administered through Medicare Australia; and
2. A payment for clinical care provided by Allied Health Professionals in RACFs, where these services are not currently covered by Medicare or other government funding arrangements. This component will be managed by State Based Organisations in each state and territory which may purchase allied health services directly or through contractual arrangements with Divisions of General Practice.

As at May 2009, approximately 4,200 GPs had qualified for the first ($1,000) incentive payment for providing 60 or more services in residential aged care facilities. Of these GPs, approximately 2,600 also received the second tier ($1,500) payment for providing 140 or more residential aged care facilities services. In total, around $8 million was paid to eligible GPs.

Progress reports for the six months to the end of December 2008 indicate that allied health services most commonly provided have been podiatry, speech pathology, physiotherapy and psychology services, through either individual or group sessions. Information on the allied health component for the full 2008-09 year will be available in November 2009.

Medical Services in Residential Aged Care Facilities
The following measures have been taken to improve the level and quality of medical care for residents in aged care facilities.

1. Non-referred attendances at residential aged care facilities (RACFs) – in hours
A range of time-based rebates are available to GPs who attend on their patients residing in aged care facilities. These rebates are higher than those for other out of surgery consultations. These higher rebates were introduced in November 2007 (MBS item nos 20, 35, 43, 51, 92, 93, 95 and 96).

2. Non-referred attendances at RACFs – after hours
A range of similar but higher-rebated rebates are available to GPs who attend on their RACF patients after hours. These rebates are higher than those for other out of surgery consultations after hours. These higher rebates were introduced in November 2007 (MBS item nos 5010, 5028, 5049, 5067, 5260, 5263, 5265, 5267).

3. Comprehensive Medical Assessment

The Comprehensive Medical Assessment (CMA), MBS Item Number 712, was introduced in July 2004. The CMA provides an opportunity for General Practitioners to undertake a full systems review of new and existing residents of Residential Aged Care Facilities including assessment of the resident's health and physical and psychological function. It involves a GP taking a detailed relevant medical history, conducting a comprehensive medical examination, developing a list of diagnoses or problems, and providing a written summary of the outcomes of the CMA for the resident's records.

CMAs complement other services that GPs can provide to residents of Aged Care Facilities, including normal consultations and Enhanced Primary Care (EPC) services for contribution to a care plan and for case conferencing. Information from the CMA can help inform a GP's contribution to a multidisciplinary care plan for a resident. Where a GP has contributed to a resident's care plan, the resident is then eligible to access Medicare items for certain allied health and dental services on referral from the GP.

4. Chronic disease management

Commonwealth-funded aged care residents are required to have a care plan prepared for them by the aged care facility, usually on admission or soon after arriving at the facility. Where the care plan is for a resident with a chronic medical condition and complex care needs, their usual GP is able to contribute to the resident's care plan and claim a Medicare rebate using MBS item 731.

Once a GP has contributed to a resident's care plan, the resident is eligible for Medicare rebates for up to five allied health services per year (MBS items 10950 – 10970). The need for allied health services must be identified in the resident's care plan.

It should be noted that high care residents should not be routinely referred for Medicare subsidised allied health services. High care residents should already be receiving these services, at no cost to them, through the aged care facility. Approved providers of residential aged care have an obligation under the *Aged Care Act 1997*, where an assessed need has been identified, to provide allied health services to high care residents at no cost (except for intensive long term rehabilitation services following serious injury, surgery or trauma).

5. Multidisciplinary case conferences

A Medicare rebate is payable where a GP organises and coordinates or participates in a multidisciplinary case conference for a resident of an aged care facility. To be eligible, the resident must have a chronic medical condition and complex care needs. A multidisciplinary case conference is a meeting at which the patient's usual GP and at least two other health or care providers discuss the patient's care needs and identify ways to better coordinate the services that the patient receives. It is expected that a resident would not normally require more than five case conferences in a 12 month period (MBS item nos734, 736, 738, 755, 778, 779).

MBS claims for services provided by GPs in residential aged care facilities increased by approximately 12% in the period 1 July 2008 to 28 February 2009 compared to the corresponding period in the previous financial year.

6. Residential Medication Management Review (RMMR)

The RMMR is designed to reduce the risk of unintentional misuse of medicines. A Medicare rebate is available for GPs to work collaboratively with pharmacists to review the medication regimes of residents who are at risk of medication-related problems. RMMRs are available to all new residents of aged care facilities and to existing residents every 12 months, or more frequently if clinically required (MBS item no 903).

Development of the National Primary Health Care Strategy

As part of the Government's reform agenda, Australia's first National Primary Health Care Strategy is being developed. The Strategy will address primary health care services for all Australians, including people living in aged care facilities.

The Strategy will provide a road map for the future directions of primary health care in Australia, and examine how Australian Government support for the primary health care sector can better identify and reward preventive health care, and better support patients with chronic disease in managing their conditions.

It will also consider the role GPs play in the health care team, and address the growing need for access to other health professionals, including practice nurses and allied health professions, such as physiotherapists and dietitians, with an emphasis on multidisciplinary team-based care.

A draft Strategy is expected to be available for Minister Roxon's consideration in mid-2009.

Nurse Practitioners Program

The 2009-10 Commonwealth Budget includes a measure which will enable eligible nurse practitioners to provide certain Medicare rebateable services and certain subsidised PBS medications to their patients from November 2010. Nurse practitioners are already able to undertake a range of medical service and prescribing tasks under relevant State and Territory legislation which determine their scope of practice, however not on a basis subsidised through the MBS or PBS.

The measure supports the optimal use of nurse practitioners which will help improve the overall capacity, efficiency and productivity of Australia's health workforce, including in the aged acre sector.

Supporting nurse practitioners in this way will also enable medical practitioners to focus their effort on tasks that require their level of skill and expertise and will facilitate a multidisciplinary, team based approach to care through collaborative working arrangements.

A significant amount of work needs to occur in order to enable nurse practitioners to access the MBS and PBS from November 2010. This includes legislative and regulatory amendments and the development of Medicare systems.

It is anticipated that some of the specific and technical details of the measure will need to be developed in consultation with key stakeholders, including nursing, medical and other health care representatives. This will include consideration of issues related to the aged care sector and aged care facilities. Ms Rosemary Bryant, the Chief Nurse and Midwifery Officer, will play an important role in the consultation process.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-020

OUTCOME 4: Aged Care and Population Ageing

Topic: NURSING HOME DEATHS

Written Question on Notice

Senator Ryan asked:

In each of the last two years (2007 and 2008), how many deaths of residents of nursing home facilities have been attributed to each of:

a) Pneumonia?
b) Falls?
c) Gastro-type illnesses (eg gastro-enteritis)?
d) Pressure wounds?
e) Could you please provide a state-by-state breakdown of the above results?

Answer:

a– e)

The Department of Health and Ageing does not collect data on the causes of death of residents of aged care homes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-072

OUTCOME 4: Aged Care and Population Ageing

Topic: FOUR CORNERS

Written Question on Notice

Senator Xenophon asked:

What is DOHA's response to claims made by the Four Corners program on 1 June 2009 that the existing compliance scheme investigates processes rather than specific complaints?

Answer:

The Aged Care Complaints Investigation Scheme (CIS) investigates specific complaints made in regard to Commonwealth subsidised aged care services. CIS Investigators that follow up complaints take into consideration a range of matters, including, but not limited to: discussions with the care recipients and his/her family as appropriate; discussions with staff and other appropriate health professionals; and written material which must be taken into consideration, but not to the exclusion of discussions with the parties involved in the complaint.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-129

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 48

Senator Cormann asked:

Budget of the financial years 2007-08, 2008-09 and 2009-10 for the scheme?

Answer:

	2007-08 $'000	**2008-09 $'000**	**2009-10 $'000**
Departmental	22,683	23,591	24,792
Administered	(933)	(951)	(969)
Departmental Capital	2,215	1,805	-
Total	23,965	24,445	23,823

This information is from page 15 of the *Portfolio Additional Budget Estimates Statements 2006-07*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-130

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 48

Senator Cormann asked:

Month by month breakdown of complaints received by the scheme for the calendar year 2008?

Answer:

The Scheme received 11,624 contacts in the 2008 Calendar year and investigated those which related to an approved providers responsibilities under the *Aged Care Act 1997.*

	Jan	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sep**	**Oct**	**Nov**	**Dec**	**Total for 2008**
Total	954	917	849	837	953	927	999	1064	1100	1132	1020	872	**11624**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-131

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 48

Senator Cormann asked:

a) Can you give us a breakdown on the nature of the complaints?
b) Can you give us a list of the proportions and types?

Answer:

a) The *Report on the Operation of the Aged Care Act 1997*, 1 July 2007 to 30 June 2008, provides the most recent data on the most commonly reported issues. In-scope contacts received by the Aged Care Complaints Investigation Scheme (CIS) often include more than a single issue. During the reporting period, 1 July 2007 to 30 June 2008, from the 11,323 complaints received, 13,789 individual issues were identified. The majority of these issues were grouped under the following five keywords:
   - Health and personal care;
   - Consultation and communication;
   - Physical environment;
   - Personnel; and
   - Abuse.

b) Of the above issues, for the reporting period 1 July 2007 to 30 June 2008, there were:
   - 3,106 (23%) health and personal care issues;
   - 1,598 (12%) consultation and communication issues;
   - 1,496 (11%) physical environment issues;
   - 1,255 (9%) personnel issues; and
   - 1,117 (8%) relating to issues of abuse.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-214

OUTCOME 4: Aged Care and Population Ageing

Topic: ONGOING CARE OF RESIDENTS FOLLOWING CLOSURE OF RESIDENTIAL AGED CARE FACILITIES

Written Question on Notice

Senator Adams asked:

a) What provision has the department made to provide care for frail aged residents when some large and small aged care providers close down?
b) If nothing, what then happens to these residents if family are unable to care for them?

Answer:

a and b)

Under Division 56 of the *Aged Care Act 1997*, and the associated User Rights Principles, a residential aged care provider who proposes to close a residential aged care service is required to satisfy the Department of Health and Ageing that realistic options or arrangements for relocation are made to ensure the continuing well being and care of the residents.

The approved provider must not take action to make the resident leave the service, or imply that the resident must leave the service, before suitable, alternative, affordable accommodation is available that meets the assessed long-term needs of the resident.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-018

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE HOMES UNDER SANCTION

Written Question on Notice

Senator Ryan asked:

How many aged care residential facilities have been under sanction in the past year across Australia, and how many residents reside in each home in:

a) Victoria
b) New South Wales
c) Queensland
d) South Australia
e) Western Australia
f) Tasmania
g) Australian Capital Territory
h) Northern Territory

Answer:

a-h)
For the period 1 July 2008 to 30 June 2009 there have been 30 sanctions issued against 29 facilities.

State	**Facility Name**	**Date Sanction Imposed**	**Number of Residents at time of Sanction**
VIC	Parkdale House	11-July-2008	58
	Patricia Gladwell Aged Care Home	28-August-2008	56
	Lakes Entrance Aged Care Facility	17-September-2008	53
	Latrobe Private Nursing Home	01-November-2008	28
	Grandview Gardens Aged Care Facility	04-March-2009	59
	Yarra Valley Hostel	08-April-2009	34
	Yarra Valley Nursing Home	26-March-2009	51
	Werribee Terrace Aged Care	08-March-2009	70
	Domain Seahaven	12-May-2009	103
	St Benedicts Private Nursing Home	22-May-2009	31
	Rosden Private Nursing Home	23-September-2008	57

	Kirralee Residential Aged Care Facility	18 and 25 July-2008	98

NSW	Glenwood Gardens	03-October-2008	48
	Bethany Nursing Home	16-March-2009	50
	Bethany Hostel	16-March-2009	40
	Vincent Court	05-June-2009	93
QLD	Albany Gardens Nursing Centre	04-July-2008	71
	Rockingham Cardwell Shire Home for the Aged	14-August-2008	51
	Sir James Terrace	16-August-2008	44
	Raffin Place	13-December-2008	117
	Mareeba Garden Settlement Hostel	17-December-2008	32
	Diji Meta Aged and Disabled Hostel	31-March-2009	34
SA	Salisbury Gardens Aged Care Service	09-July-2008	71
	Charles Young Residential Care Centre	08-December-2008	156
	Norwood Nursing Home	08-April-2009	39
WA	Numbala Nunga Nursing Home	23-January-2009	30
	John Mercer Lodge	07-October-2008	102
NT	Katherine Red Cross Centre	17-April-2009	29
TAS	North East Aminya Hostel	11-June-2009	30

*Note: No facilities in ACT have been subject to sanctions for the period 1 July 2008 to 30 June 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-064

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE PROVIDERS

Written Question on Notice

Senator Williams asked:

Why are residential aged care providers not funded the same as multi-purpose centres?

Answer:

The different funding methods reflect the nature of the services provided. Residential aged care provides aged care services (including assistance with activities of daily living) and accommodation to older people whose care needs are such that they can no longer remain in their own homes. Multi-Purpose Services (MPS) are a joint initiative between the Australian Government and those states and territories that need such services. MPS deliver a mix of aged care, health and community services and are funded by the Australian Government and the relevant state and territory government.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-125

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME (CIS)

Hansard Page: CA 46

Senator Cormann asked:

When did the Department first hear of the review into the CIS?

Answer:

Since the inception of the CIS, the Department has undertaken an iterative improvement process in response to operational lessons learnt. The Department holds regular, broad ranging, discussions with the Minister about the aged care quality framework, including the operations of the CIS. Specific advice in relation to the review of the CIS was requested from the Department by Minister Elliot's office on 13 May 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-220

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE

Written Question on Notice

Senator Adams asked:

What funding has been offered to test new ways of designing and delivering services that enable older people to access the services and supports they need whilst continuing to live in their communities and participate in community life?

Answer

The Australian Government has made the following funding available to state and territory governments to support projects to improve access to community care services and support for ageing people, younger people with a disability and their carers.

1. **A New Strategy for Community Care – The Way Forward** – $26.1 million over the financial years 2006-07 to 2009-10.

2. **Home and Community Care Bonus Pool** – Funds of $30 million were made available through the Home and Community Care (HACC) Review Agreement, signed in June 2007, for state and territory governments that implement Common Arrangements in the HACC Program in a timeframe agreed with the Australian Government.

3. **HACC Growth Funding -** state and territory governments are allocated growth funding each year within HACC Program. As well as increasing funds for existing services, growth funding may be used to support development of new services and innovative approaches. The real growth percentage applied to annual HACC funds (which includes the amount provided in the previous year multiplied by an indexation factor) varies between jurisdictions. Whilst the Australian Government provides an average of 6 per cent real growth nationally, each state and territory is offered and matches at different rates of percentage growth. In 2008-09, the Australian Government provided $61.733 million in growth funding to the HACC Program nationally, this was part of the total Australian Government contribution to the HACC Program of $1,090.620 million.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-338

OUTCOME 10: Health System Capacity and Quality

Topic: PALLIATIVE CARE INITIATIVES AND FUNDING SOURCES FOR PALLIATIVE CARE

Hansard Page: CA 58

Senator Cormann asked:

a) Would you please itemise the expenditure on palliative care over the out-years? Could you show where it is, item by item, allocation by allocation?
b) Could the Department please also provide a list of organisations and their principals that have or will receive money under this program and the amounts of money these organisations will receive?

Answer:

a) Over the years 2009-10 to 2012-13 inclusive, $14 million is provided for continuation of the National Palliative Care Strategy, $57 million for Palliative Care in the Community and $22 million for Local Palliative Care Grants.

b) The organisations receiving funding under this program, and their principals, are shown in the attached table.

	Organisation	Principals	Funding 2009-10 (GST Inc)
Palliative Care Research Program	National Health and Medical Research Council (NHMRC)	CEO - NHMRC (See Note 1)	$1,300,000
Palliative Care Assessment Tool and Referral Guidelines	University of Newcastle	Director Centre for Health Research & Psycho-oncology	$50,000
Palliative Care Knowledge Network/CareSearch	Flinders University of South Australia	Manager Palliative Care Knowledge Network	$1,300,000
Palliative Care Outcomes Collaboration	University of Wollongong	Director Centre for Health Service Development	$450,000
Palliative Care Clinical Studies Collaborative	Flinders University of South Australia	Head of Department Department of Palliative and Supportive Services	$2,400,000
Program of Experience in the Palliative Approach	Queensland University of Technology	Director Centre for Palliative Care Research and Education	$1,900,000
Palliative Care Curriculum for Undergraduates	Queensland University of Technology	Director Centre for Palliative Care Research and Education	$180,000
Respecting Patient Choices Project	Austin Health	Program Director	$900,000
Palliative Care Australia Core Funding	Palliative Care Australia (PCA)	CEO - PCA	$620,000
National Standards Assessment Program	Palliative Care Australia (PCA)	CEO - PCA	$377,000
Paediatric Palliative Care Resource	Palliative Care Australia (PCA)	CEO - PCA	$150,000
Rural Palliative Care Project	Australian General Practice Network (AGPN)	CEO - AGPN	$470,000
People Living at Home	State and Territory Governments	State and Territory Health Departments	$1,500,000
Local Palliative Care Grants Program	See Note 2	See Note 2	$220,000

Note 1: Details of current and past grants are published here:
http://www.nhmrc.gov.au/grants/rounds/palliative.htm

Note 2: Details of recent and current projects are published here:
http://www.health.gov.au/internet/main/publishing.nsf/Content/palliativecare-local-round-4

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-063

OUTCOME 4: Aged Care and Population Ageing

Topic: CONDITIONAL ADJUSTED PAYMENT PERCENTAGE

Written Question on Notice

Senator Williams asked:

Why was there no increase in the Conditional Adjusted payment percentage in the 2009-10 budget for residential aged care?

Answer:

The Conditional Adjustment Payment (CAP) was initially set at 1.75 % of the basic subsidy amount and was set to increase by 1.75 percentage points each year for three years thereafter. The Rudd Government, however, implemented a fourth increase in the 2008-09 Budget, taking CAP to 8.75% of the basic subsidy amount.

The 2009-10 Budget and Forward Estimates continued the CAP funding at 8.75 % of the basic subsidy ongoing.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-127

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME (CIS)

Hansard Page: CA 46

Senator Cormann asked:

When was the Department asked to provide preliminary thought into the review of the CIS?

Answer:

Since the inception of the CIS, the Department has undertaken an iterative improvement process in response to operational lessons learnt. The Department holds regular, broad ranging, discussions with the Minister about the aged care quality framework, including the operations of the CIS. Specific advice in relation to the review of the CIS was requested from the Department by Minister Elliot's office on 13 May 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-132

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 48

Senator Cormann asked:

How much do you invest in advertising in the CIS?

Answer:

The Department has invested $376,454 in promotional material since the commencement of the Aged Care Complaints Investigation Scheme (CIS) in May 2007. This has included publication of brochures, posters, fact sheets (including multi-lingual versions) and the distribution of these materials to approved providers and aged care interest groups. Reproduction of these materials is on a needs basis.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-133

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 49

Senator Cormann asked:

The exact proportion of complaints that are investigated?

Answer:

The Aged Care Complaints Investigation Scheme (CIS) investigates'in scope' cases. An 'in scope' case is one in which the issues raised with the CIS relate to a Commonwealth funded approved provider's responsibilities under the *Aged Care Act 1997*. For the period 1 July 2007 to 30 June 2008, there were 11,323 contacts with the CIS and of these 7,496 were considered to be 'in scope' and were investigated.

An 'out of scope' contact is one in which the issues raised are not within the parameters of the *Aged Care Act 1997*; in these instances CIS officers may refer the matter to an appropriate body (i.e. State/Territory government). All calls are taken and considered by the CIS before a decision can be made as to whether a case is in or out of scope.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-134

OUTCOME 4: Aged Care and Population Ageing

Topic: COMPLAINTS INVESTIGATION SCHEME

Hansard Page: CA 50

Senator Cormann asked:

a) How do you determine the level of risk to the resident?
b) What are the things that you are looking for?

Answer:

a and b)

All in scope cases with the Aged Care Complaints Investigation Scheme (CIS) are assessed on an individual basis to identify the issues and associated risk. Each case is assigned a priority of critical, major or minor, which in turn determines the timeframe in which the case is investigated.

In determining if a case is critical, CIS investigation officers look for issues which may potentially have an immediate impact on the health, safety and well-being of care recipients and could result in death or serious harm. For example: allegation of sexual or serious physical assault; or medication issues.

In classifying a case as major, CIS investigation officers look for issues which could result in harm to a care recipient, but are unlikely to result in death or serious harm. For example: continence management or personal hygiene.

Minor issues are those that pose minimal risk of harm to care recipients. This may include: the variety of meals; communication; or requests for information.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-136

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE WORKFORCE

Hansard Page: CA 65

Senator Adams asked:

a) And how many people have taken up those scholarships?
b) Is that what has gone out?
c) Is that what you mean by offered?

Answer:

a) Of the 2,459 scholarships offered to successful applicants, 2,401 scholarships were taken up.

b) Scholarships have been offered to 2,459 successful applicants and 2,401 of these were taken up. However, 398 scholars have subsequently withdrawn from their course, forfeiting their scholarship.

c) The number of scholarships offered indicates the number of successful applicants who were offered a scholarship under the aged care nursing scholarship scheme.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-200

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE FACILITIES

Written Question on Notice

Senator Adams asked:

Can you explain why the Minister still refers to all residential aged care facilities as 'nursing homes' when that term was superceded by the *Aged Care Act 1997*, and only appears in the act in relation to pre-1997 issues?

Answer:

While the term 'nursing home' is not defined in the *Aged Care Act 1997*, it is a term that continues to be used widely by the aged care sector (many services have the term 'nursing home' in their title), and it is a term widely used and understood by the general community.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-201

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL CARE

Written Question on Notice

Senator Adams asked:

Pre 1997 a 'nursing home' provided care and services to residents needing high care. Does the Minister mean to imply the end to residential care facilities that only provide care to residents who have low care needs?

Answer:

No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-203

OUTCOME 4: Aged Care and Population Ageing

Topic: INTEREST IN THE PROVISION OF RESIDENTIAL AGED CARE

Written Question on Notice

Senator Adams asked:

As the Baby Boomers begin to retire and there is an increase in people requiring some form of care, many people are concerned that if the proportion of places applied for are so small in comparison to the numbers available, how can the department alleviate concern that there will be adequate aged care in the next decade?

Answer:

The Department allocated 10,447 aged care places in June 2009 with an estimated $397 million in annual recurrent funding.

Over the next three years, the Rudd Government will create more than 37,000 new aged care places.

The Rudd Government is providing further support for capital investment in residential aged care through the Zero Real Interest Loans initiative. Access to $300 million in zero real interest loans was provided for in the 2008-09 Budget to build or expand aged care homes, to deliver up to 2,500 new beds in areas of high need. The first loans round offering $150 million in zero real interest loans and associated residential aged care places was undertaken last year (2008), and a second round for the balance of the funding is planned for later this year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-204

OUTCOME 4: Aged Care and Population Ageing

Topic: TIMING OF THE 2009-10 AGED CARE ALLOCATION ROUND

Written Question on Notice

Senator Adams asked:

When is it proposed to conduct the next ACAR round?

Answer:

It is expected that the invitation to apply for the 2009-10 Aged Care Approvals Round will be later this year, 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-206

OUTCOME 4: Aged Care nd Population Ageing

Topic: AGED CARE WORKERS

Written Question on Notice

Senator Adams asked:

If the aim is to increase the number of workers in the industry, what is being done to encourage this if it is well known they are less well paid than other sectors?

Answer:

The Australian Government has a number of programs in place to promote a skilled workforce in aged care. The strategies include creating better career paths for personal care workers by supporting training, providing nursing scholarships, and cash bonuses for nurses returning to work under the Bringing Nurses Back into the Workforce program.

Funding of $6.9 million over five years from 2007-08, has been allocated to increase the number of qualified nurses in aged care services by providing a cash bonus of $6,000 each for up to 1,000 nurses who return to work in the aged care sector after at least a 12 month absence. An additional $1,000 is being provided to aged care providers for each eligible nurse they employ to assist with the cost of re-training and re-skilling the nurse.

Through the Productivity Places Program, the Government is also providing an additional 711,000 training places as part of the *Skilling Australia for the Future* initiative. Over the three years from 2008-09, up to 50,000 additional places will be made available for areas of national skills shortage in health occupations, including personal care workers. As at 8 May 2009, the program has attracted 10,279 enrolments in the Certificate III in Aged Care.

These measures, complementing established programs to increase overall staff supply and improve career paths for care workers, will go some way to addressing workforce shortages in aged care. The aged care sector also has a responsibility to develop its own responses to address its workforce issues and improve recruitment and retention of staff in aged care.

Increased funding from the Rudd Government will bring direct financial support for aged and community care providers who care for older Australians to a record level of $44 billion over the next four years. That is more than $2.5 billion over previous projections for aged and community care. This funding enables care providers to pay adequate wages to staff which is important to staff recruitment and retention. However, the Government does not set wages or

determine employment conditions for staff in the aged care sector; this is a matter for negotiation between employers and employees.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-207

OUTCOME 4: Aged Care and Population Ageing

Topic: Aged Care Workers

Written Question on Notice

Senator Adams asked:

Most aged care workers are Baby Boomers and are nearing retirement in the next 10 years. This means they will be retiring along with the rest of the Baby Boomers, people requiring aged care will be increasing and yet there will be no more aged care working.

a) Can you explain how you are going to attract younger employees?

b) It was recently published that Gen Ys expect a 10% increase in salary compared to an average for Baby Boomers of 3% or no increase. What will you do to attract younger people to a low paying job?

c) What is being done in relation to recognition of professional skills of Assistants in Nursing and care staff through a national licensing system?

Answer:

a and b)

The Australian Government has a number of programs in place to promote a skilled workforce in aged care. The strategies include creating better career paths for personal care workers by supporting training, providing nursing scholarships, and cash bonuses for nurses returning to work under the Bringing Nurses Back into the Workforce program.

Funding of $6.9 million over five years from 2007-08, has been allocated to increase the number of qualified nurses in aged care services by providing a cash bonus of $6,000 each for up to 1,000 nurses who return to work in the aged care sector after at least a 12 month absence. An additional $1,000 is being provided to aged care providers for each eligible nurse they employ to assist with the cost of re-training and re-skilling the nurse.

Through the Productivity Places Program, the Government is also providing an additional 711,000 training places as part of the *Skilling Australia for the Future* initiative. Over the three years from 2008-09, up to 50,000 additional places will be made available for areas of national skills shortage in health occupations, including personal care workers. As at 8 May 2009, the program has attracted 10,279 enrolments in the Certificate III in Aged Care.

These measures, complementing established programs to increase overall staff supply and improve career paths for care workers, will go some way to addressing workforce shortages

in aged care. The aged care sector also has a responsibility to develop its own responses to address its workforce issues and improve recruitment and retention of staff in aged care.

Increased funding from the Rudd Government will bring direct financial support for aged and community care providers who care for older Australians to a record level of $44 billion over the next four years. That is more than $2.5 billion over previous projections for aged and community care. This funding enables care providers to pay adequate wages to staff which is important to staff recruitment and retention.

c) The Council of Australian Governments signed an Intergovernmental Agreement on 26 March 2008 to establish a National Registration and Accreditation Scheme for health practitioners by 1 July 2010. The National Registration and Accreditation Scheme for health practitioners will initially cover the ten professions of chiropractic, dental, optometry, osteopathy, medicine, nursing and midwifery, pharmacy, physiotherapy, podiatry and psychology. The inclusion of other professions will be determined by Health Ministers on a case by case basis following assessment against an agreed set of criteria.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-209

OUTCOME 4: Aged Care and Population Ageing

Topic: WAGES OF AGED CARE WORKERS

Written Question on Notice

Senator Adams asked:

Public and many private hospitals are able to pay their nurses and other care staff some 20% more than the aged care providers. Isn't it time that the Minister for Ageing provided adequate funding to enable aged care providers to be able to pay their nurses and personal carers the same rates as public hospitals?

Answer:

The Australian Government is committed to supporting a sustainable and skilled aged care workforce and is increasing funding to the aged care sector to enable higher quality care. Over the next four years, funding for aged and community care will reach more than $44 billion.

The Government does not set wages or determine employment conditions for staff in the aged care sector. In general, wages and conditions are a matter for negotiation between employers and employees.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-210

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE WORKFORCE

Written Question on Notice

Senator Adams asked:

What provision has the Government made to improve the clinical skills of care staff in residential and community-based services so staff are better able to care for increasing numbers of older people with complex health care needs and end of life care needs?

Answer:

The Rudd Government is committed to quality care for older Australians and has a number of initiatives in place to improve the clinical skills of care staff in residential and community-based services.

- There are several programs aimed at improving the clinical skills of residential and community aged care staff:
- Encouraging Best Practice in Residential Aged Care (EBPRAC);
- Better Skills for Better Care;
- Support for Aged Care Training;
- Community Aged Care Workforce Development Program;
- Postgraduate Community Aged Care Scholarship Scheme;
- More Aged Care Nurses program;
- Bringing the Nurses Back into the Workforce; and
- Support for Better Practice models for use in community care services including respite.

The Dementia Behaviour Management Advisory Service (DBMAS) has been established in each state and territory. These services provide appropriate clinical interventions to help aged care staff and carers improve their care of people with dementia.

The Government has also issued *Guidelines for a Palliative Approach in Residential Aged Care* for staff in residential aged care services and the Program of Experience in the Palliative Approach allows residential and community aged care workers to obtain in-service palliative care training.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-211

OUTCOME 4: Aged Care and Population Ageing

Topic: DEMENTIA SPECIFIC FACILITIES

Written Question on Notice

Senator Adams asked:

a) Are you aware that in the South West, Mid West, Great Southern and Wheatbelt areas of Western Australia, there are no Dementia specific facilities outside the major regional centres?
b) Currently the specific needs of residents with dementia from these areas are mixed unsatisfactorily with other Nursing home type patients in so-called 'Secure Facilities', which are not designed to support dementia needs?
c) Is there any indication that dementia specific facilities will be built in rural areas outside of regional centres to service this increasing area of need, and will the Government be providing building capital for this to occur?

Answer:

a) A number of facilities in the South West, Mid West, Great Southern and Wheatbelt areas of Western Australia contain dementia specific beds.

b) The model developed for dementia care in many such areas is to provide secure, specialised parts of wings within aged care facilities that cater specifically for the needs of residents with dementia who wander or have behavioural issues.

   Under Accreditation requirements, appropriate care must be provided to residents based on their care needs, and this applies whether the resident is within the secure area or the main facility.

c) In some rural areas the model for care provision is the Multi Purpose Service or an integrated facility with dementia care provided in secure or separate parts of the facility.

   Aged care providers are already able to apply for capital to modify or extend existing facilities to cater for residents with dementia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-217

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE PLACES FOR WESTERN AUSTRALIA

Written Question on Notice

Senator Adams asked:

a) As there was a significant shortfall in the number of residential care places applied for in WA to the number of residential places offered, is it true the Department is intending to allocate out more CACPs and EACH(D) to ensure the process is fair and equitable?
b) If so to ensure the process is fair and equitable, how will these additional places be allocated and what provision will be made for providers located within regions that did not have any community packages to apply for and therefore did not apply for CACPs or EACH(D)?

Answer:

a) All 1,544 places available for Western Australia were allocated in the 2008-09 Aged Care Approvals Round but with a higher than expected proportion of CACP, EACH and EACH (D) places, reflecting a higher demand for these places.

b) In response to the 336 community places made available, 50 of which were made available to all regions in Western Australia, 122 applications were received seeking in excess of 2,000 places.

   In making the additional community care places available, it was possible to maximise the allocation of places to those applicants who were assessed against the legislatively prescribed assessment criteria as demonstrating they were best able to meet the aged care needs of the community.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-218

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE PACKAGES

Written Question on Notice

Senator Adams asked:

Why hasn't the government announced any new community care packages for 2 years when more people wish to remain at home and the ageing population is increasing?

Answer:

The results of the 2008-09 Aged Care Approvals Round were announced on 30 June 2009. Nationally, 4,699 new community care places (comprising 2,944 Community Aged Care Packages, 1,193 Extended Aged Care at Home packages and 562 Extended Aged Care at Home Dementia packages) were approved for allocation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-219

OUTCOME 4: Aged Care and Population Ageing

Topic: COMMUNITY CARE PACKAGES

Written Question on Notice

Senator Adams asked:

When will the government release new community care packages and will they and current packages be indexed to reflect the real increase in costs so that the level of care is not decreased?

Answer:

Community Care packages are generally released as part of the annual Aged Care Approvals Round.

The results of the 2008-09 Aged Care Approvals Round were announced on 30 June 2009. Nationally, 4,699 new community care places (comprising 2,944 Community Aged Care Packages, 1,193 Extended Aged Care at Home packages and 562 Extended Aged Care at Home Dementia packages) were approved for allocation.

Australian Government subsidies paid to community aged care providers are indexed on 1 July each year.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-270

OUTCOME 4: Aged Care and Population Ageing

Topic: ZERO REAL INTEREST LOANS

Hansard Page: CA 36

Senator Cormann asked:

a) Will the Government be releasing the report on the review of Round 1 of the Zero Real Interest Loans?
b) If the report is not to be released what is the public interest ground on which the refusal is based and why is it not in the public interest for the information to be released?

Answer:

a) The Department will release it in due course.

b) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-271

OUTCOME 4: Aged Care and Population Ageing

Topic: RETURN ON INVESTMENT

Hansard Page: CA 38

Senator Cormann asked:

What is the full analysis and methodology used to arrive at the conclusion that there was a 10% return on investment on 31 December 2008?

Answer:

This figure was derived from an analysis of the financial performance of the providers in the top quartile as assessed by their earnings before interest, tax, depreciation and amortisation (EBITDA).

The 10 per cent was calculated on the average EBITDA of $15,650 for the top quartile as against the average capital cost per resident ($150,000) as determined from Rawlinsons' Construction Cost Guide 2009 (consistent with the findings in the most recent departmental survey of aged care homes).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-275

OUTCOME 4: Aged Care and Population Ageing

Topic: CAP REVIEW

Hansard Page: CA 59

Senator Siewart asked:

Can you provide a breakdown of the data of organisation types in the top quartile?

Answer:

A summary of the unit data available from the Bentley's 2007-08 Survey shows that the organisation types in the top quartile are as follows:

TOP QUARTILE		**Number of Services**	**Average EBITDA per resident per annum**	**Average number of residents per service**
All Top Quartile				
	Not-for-profit	51	$11,419	65
	For-profit	9	$15,390	68
	Total	**60**	**$12,034**	**66**

EBITDA = Earnings before interest, tax, depreciation and amortisation

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-016

OUTCOME 4: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE FACILITIES

Written Question on Notice

Senator Ryan asked:

Is there an objective measure of profitability of Australia's residential aged care facilities? If so, what are the results for each state and territory?

Answer:

Earnings before interest, tax, depreciation and amortisation (EBITDA) is a measure of financial performance that is accepted within the aged care industry. The unit data of the Bentley's 2007-08 Survey provides an EBITDA per resident per annum for each service in the sample**.** A summary of the average EBITDA by state for the top quartile of services in the 2007-08 Survey is as follows.

	Top Quartile
	Average EBITDA prpa
New South Wales	$11,718
Victoria	$11,785
Queensland	$11,658
South Australia	$12,443
Western Australia	$13,127
Australia	**$12,034**

EBITDA = Earnings before interest, tax, depreciation and amortisation
prpa = per resident per annum

Note: The Bentley's 2007-08 Survey sample does not contain sufficient aged care services in to allow reliable averages to be computed for Tasmania, the Australian Capital Territory and the Northern Territory.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-019

OUTCOME 4: Aged Care and Population Ageing

Topic: NURSING HOME RESIDENTS ADMITTED TO HOSPITAL

Written Question on Notice

Senator Ryan asked:

In each of the last two years (2007 and 2008) how many hospital presentations have there been residents of nursing home facilities across Australia for each of:

a) Pneumonia;
b) Falls;
c) Gastro type illnesses;
d) Pressure wounds; and
e) State by state breakdown.

Answer:

The Department does not hold this data.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-202

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

In relation to subsidies, The Minister stated on 'The National Interest' program on Radio National on 1 June 2009 that average funding per resident in aged care is $60,000 per year.

a) That equates to $ 164 per resident per day?

b) Was this amount inclusive of capital subsidies?

c) What is the average per day subsidy for recurrent funding?

Answer:

a) For 2009-10, the average total revenue per resident across all aged care providers is estimated to be about $62,600 per year which equates to about $170 per day.

b) Yes.

c) Government subsidies are paid as a contribution to the costs of providing care and accommodation and are not allocated to specific cost components.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-269

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE FUNDING GROWTH

Written Question on Notice

Senator Xenophon asked:

Explain the factors included in the aged care funding growth including;

a) Indexation cocktail;
b) Dependency
c) Client numbers; and
d) New policy.

Answer:

a - d)

An explanation of the funding growth was set out in the Department's supplementary submission to the Senate Finance and Public Administration Committee's Inquiry into Residential and community aged care in Australia. This is available on the parliament house website at: http://www.aph.gov.au/Senate/Committee/fapa_ctte/aged_care/index.htm.

Funding for residential aged care in 2008-09 was estimated to be more than 10 per cent higher than in 2007-08.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-272

OUTCOME 4: Aged Care and Population Ageing

Topic: PROPORTION OF HIGH CARE RESIDENTS WHO ROLLED OVER FROM LOW CARE

Hansard Page: CA 40

Senator Cormann asked:

a) What was the total value of the rolled-over bonds, based on their value when rollover occurred? Some people, I understand, would not have rolled them over, but what is the total value of rolled-over bonds based on their value when rollover occurred?
b) What proportion of total high-care residents on 31 December 2008 were former low-care residents who had rolled over their bond?
c) How many of the developments involving newly allocated places, either as new services or extensions of existing services, involve a mix of high and low care places or extra services, or are in some way created so that a continuum of care can be provided which would allow bonds to be tapped and rolled over into high care?

Answer:

a) It is not possible for the Department to determine the value of bonds that have been rolled over.

b) As at 31 December 2008, there were approximately 113,300 permanent residents in high care. Of these, approximately 38,400 residents (34%) were first admitted into that service with a low ACAT assessment, meaning that they have since aged in place in that home.

   As outlined in the response to part a), it is not possible for the Department to determine the value of bonds that were rolled over by these residents as they moved from low to high care.

c) The number of new and existing Australian Government subsidised aged care homes which received a combination of residential low and high care places in the 2007-08 Aged Care Approvals Round (ACAR) is provided in Table 1.

Many low care facilities provide residents with ageing-in-place. That is, as residents care needs increase to a level requiring high care, residents are able to age in place within low care facilities where appropriate care is able to be provided. Bonds can also be rolled over when a resident moves from one facility to another. The value of these bonds cannot be calculated by the Department.

Table 1: Number of aged care homes which received a combination of both high and low care residential aged care places, 2007-08

Care level	New homes	Existing homes
Low and high care	32	38

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-277

OUTCOME 4: Aged Care and Population Ageing

Topic: EXCHANGE OF PLACES FOR COMMUNITY CARE PACKAGES

Hansard Page: CA 61

Senator Siewert asked:

Is it possible to give me that breakdown per year and per state in terms of the number of beds that were exchanged for community care packages from 2006 to April 2009?

Answer:

Between 1 January 2006 and 30 April 2009, a total of 267 residential aged care places were exchanged for community care packages (which includes Community Aged Care Packages, Extended Aged Care at Home and Extended Aged Care at Home –Dementia).

Number of residential aged care places exchanged for community care packages between 1 January 2006 and 30 April 2009

State/Territory	**2006**	**2007**	**2008**	**2009**	**Total**
New South Wales	62	11	6	62	**141**
Victoria	68	1	14	0	**83**
Queensland	0	0	0	10	**10**
Western Australia	0	3	23	3	**29**
South Australia	0	0	0	0	**0**
Tasmania	0	0	4	0	**4**
Australian Capital Territory	0	0	0	0	**0**
Northern Territory	0	0	0	0	**0**
Total Number of Places Exchanged	**130**	**15**	**47**	**75**	**267**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-017

OUTCOME 4: Aged Care and Population Ageing

Topic: BUILDING AND CAPITAL WORKS

Written Question on Notice

Senator Ryan asked:

In the past two years, have building and other capital works been sufficient in this sector to meet expected demand over the next 5 years?

Answer**:**

The Australian Bureau of Statistics (ABS) publishes quarterly estimates of the level of building activity in various sectors, based on building approval details and returns collected from builders and other organisations engaged in building activity. The ABS data shows that over the seven quarters from 1 July 2007 to 31 March 2009, the industry commenced work on aged care facilities with a total value of $2.2 billion. This figure is 13% higher than the value of aged care facilities commenced in the corresponding period two years earlier ($2.0 billion). (See ABS, *Building Activity, Australia, March 2009* (Cat. 8752.0), Canberra: ABS, 2009.)

In addition, the Department of Health and Ageing conducts an annual survey of aged care homes. In the 2007-08 Survey, the latest data available, aged care providers indicated that 18,700 places were being planned for construction or upgrading.

In 2007-08, the number of additional residential places that became available through completed building work was at the highest level this decade. Building work completed in 2007-08 resulted in 6,835 additional residential places for the sector, a sharp rise of 38.4 per cent on the additional places completed in 2006-07.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-062

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE SUBSIDIES

Written Question on Notice

Senator Williams asked:

Why are Aged Care subsidies still incremented in line with the Commonwealth Own Purpose Outlay?

Answer:

The current indexation arrangements for residential aged care came into effect on 1 July 1996. They seek to ensure that aged care providers are compensated for increases in their costs that are due to price movements in the economy as a whole and which therefore are not within the control of the aged care provider.

To this end, the indexation arrangements use the Consumer Price Index as a measure of movements in the non-labour costs of providers and the decisions of the Australian Fair Pay Commission as a measure of non-productivity based movements in the wage costs of providers.

Current indexation is just one measure, other measures included in the 2009-10 Budget will see the Australian Government provide a total of $9.9 billion in 2009-10 to support the aged care needs of older people. This represents an increase in funding of about 10 per cent over 2008-09 levels.

For residential care, the Government will provide $7.1 billion in 2009-10 – an increase of 9 per cent over 2008-09.

Over the next four years, the Government will be providing on average about $45,000 per resident per year to every aged care home in Australia.

Measures in the 2009-10 Budget deliver an additional $728 million over the next four years for aged care homes.

This includes $713.2 million flowing through to aged care providers from the pension increase.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-066

OUTCOME 4: Aged Care and Population Ageing

Topic: REHABILITATION SERVICES

Written Question on Notice

Senator Williams asked:

What is offered in the way of rehabilitation services to support people with a chronic illness in terms of housing etc?

Answer:

Rehabilitation and accommodation services to support people with a chronic illness are provided by state and territory governments. However, there are some Commonwealth funded community and aged care programs that provide varying levels of care or accommodation support (rather than rehabilitation) including:

- Transition Care Program (jointly funded with the states);
- Home and Community Care;
- Assistance with Care and Housing for the Aged; and
- Day Therapy Centres.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-208

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

When will the Minister of Ageing finally admit that there is a serious problem directly related to diminishing funding levels in real terms on a per funded place in aged care that is impacting upon staffing numbers employed to care for seniors?

Answer:

The Australian Government is committed to the long-term viability of Australia's aged care sector and the protection of the nation's frail and elderly. Funding for aged care over the next four years to 2012-13 is set to be about $44 billion, which is more than $2.5 billion over previous projections for aged and community care.

During 2009-10, total Australian Government expenditure for aged care will increase to $9.9 billion, including $7.1 billion for residential aged care. This represents an increase in funding of about ten per cent over 2008-09 levels. This increases follows on from an increase of more than 10 per cent in aged care funding from 2006-07 to 2007-08.

On average, aged care providers will receive a total of $62,600 to care for each resident in 2009-10, increased from about $58,600 per resident last year. This funding enables aged and community care providers to employ sufficient staff and pay adequate wages to staff.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-213

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

What provision has the Government made in the aged care program budget to provide a realistic indexation rate for aged care? A realistic indexation rate would build in capacity to match staffing remuneration with the acute care sector, to meet increasing costs of primary expenses (food, energy, building services) and fully compensate services for delivering high quality care, not just bare minimum.

Answer:

The current indexation arrangements for residential aged care came into effect on 1 July 1996. They seek to ensure that aged care providers are compensated for increases in their costs that are due to price movements in the economy as a whole and which therefore are not within the control of the aged care provider.

To this end, the indexation arrangements use the Consumer Price Index as a measure of movements in the non-labour costs of providers and the decisions of the Australian Fair Pay Commission as a measure of non-productivity based movements in the wage costs of providers.

Current indexation is just one measure, other measures included in the 2009-10 Budget will see the Australian Government provide a total of $9.9 billion in 2009-10 to support the aged care needs of older people. This represents an increase in funding of about 10 per cent over 2008-09 levels.

For residential care, the Government will provide $7.1 billion in 2009-10 – an increase of 9 per cent over 2008-09.

Over the next four years, the Government will be providing on average about $45,000 per resident per year to every aged care home in Australia.

Measures in the 2009-10 Budget deliver an additional $728 million over the next four years for aged care homes.

This includes $713.2 million flowing through to aged care providers from the pension increase.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-205

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

a) Is the Department of Health and Ageing able to provide an account of additional costs imposed upon aged care providers to cover increased regulatory and compliance costs over the past five years?
b) Can you provide a total breakdown of this?

Answer:

a and b)

The Department is unable to provide a consolidated estimate of the compliance costs of changes to regulation over the last five years.

The Department has assessed the compliance cost impact of each additional regulation introduced in recent years as minor. The impact on individual approved providers will vary depending on their business practices and processes.

There have been a number of measures introduced to reduce compliance costs, such as the introduction of the Aged Care Funding Instrument.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-212

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE

Written Question on Notice

Senator Adams asked:

With salaries and wages increasing by 3.5% subject to CWAs, catering supply costs increasing by at least 7%, electricity increasing 15% (and going up by another 10% in WA), what assistance is the government going to offer aged care providers to manage their rising costs that exceed subsidy and resident revenue in light of 'No Additional funding in Mr Swan's budget.

Answer:

The Government is committed to the long-term sustainability of Australia's aged care sector and the protection of the nation's frail and elderly. That is why funding for aged care over the next four years to 2012-13 will reach a record level of $44 billion in direct financial support for aged and community care providers who care for older Australians. This is more than $2.5 billion over previous projections for aged and community care. No Australian government has provided more.

The Government has ensured that a large proportion of the increase in the single age pension will flow through to aged care homes, as part of measures to ensure fairer and more sustainable aged care fees. The new measure will deliver $713.2 million over four years in additional payments to aged care providers.

The Government has also committed to retaining the Conditional Adjusted Payment (CAP) at the current level of 8.75 per cent on top of the basic residential care subsidy. Over the next four years, it is estimated that aged care providers will receive about $2.3 billion through this payment. The CAP payment is built into forward estimates and is ongoing.

As part of the 2009-10 Budget, the Government has also allocated $14.8 million to increase the viability supplement the Government pays to eligible residential aged care providers in regional, rural and remote areas. This brings total Government funding for the viability supplement to $72.3 million over the next four years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-216

OUTCOME 4: Aged Care and Population Ageing

Topic: AGED CARE STANDARDS AND ACCREDITATION AGENCY

Written Question on Notice

Senator Adams asked:

The Minister regularly says that over the next four years, funding for aged care and community care will reach record levels of more than $41 billion, that the Australian government will be providing an average of $43,000 for every aged care home resident per year.

a) Could you clarify whether these amounts include funding for the Complaints Investigation Scheme and the Aged Care Standards and Accreditation agency?

b) If not, how much does the Government spend annually on these two bodies?

c) Can you provide a breakdown of this funding?

Answer:

a) These figures do not include funding for the Complaints Investigation Scheme or the Aged Care Standards and Accreditation Agency Ltd.

b and c) In 2009-10:

- the Department of Health and Ageing will provide funding of $22.854 million to the Aged Care Standards and Accreditation Agency Ltd under a Deed of Funding Agreement; and
- funding of $23.823 million is available for the Complaints Investigation Scheme (refer *Portfolio Additional Budget Estimates Statements 2006-07*, p 15*).*

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

OUTCOME 4: Aged Care and Population Ageing

Topic: AUDITOR GENERAL REPORT

Written Question on Notice

Senator Xenophon asked:

The Auditor General Report (2 June 2009) found two aspects of the managing and allocating of places that need to be improved to assist transparency and planning:
The Department should provide advice to the Minister on options for incorporating numbers of Indigenous aged 50-69 population into the planning target; The Department should assess alternatives to how the department applies the national aged care ratio across states to better account for demographic differences.

f) What steps does DoHA plan to take in relation to these recommendations?

g) What are the current overall levels of bond funds being held by individual providers?

h) What are the current overall levels for regional areas?

i) What were they five years ago?

j) What were they ten years ago?

Answer:

a) In chapter two of the report the ANAO observed that "The Department could provide advice to the Minister for Ageing on options for incorporating the Indigenous population aged 50-69 into the national planning ratio target. Taking account of the Indigenous population aged 50-69 in the ratio would improve DoHA's ability to plan for the aged care needs of that population and plan the distribution of places accordingly". This observation did not form part of the overall Report recommendations.

The Auditor General Report tabled on 2 June 2009 contained two recommendations only, one of them being:

The ANAO recommends that the Department of Health and Ageing assess the merits of alternatives for how the department applies the aged care planning ratio and sub-ratios across states and territories, so as to better take account of differences in state and territory demographics, including health status.

The Department's response to this recommendation was:

The Department supports the recommendation. The Government has made a commitment to undertake a review of the planning ratio to better take account of

demographic changes and changing patterns of use of aged care services and it would be appropriate to address the issues raised as part of that review.

b) As at 30 June 2008, individual providers held $7,645,709,210 in bonds.

c) The current overall level for regional areas is $2,225,350,140. ‘Regional’ is taken to mean all aged care planning regions other than metropolitan aged care planning regions.

d) The overall level for regional areas five years ago was $1,737,508,946. ‘Regional’ is defined as at c) above.

e) The level of bonds for regional areas ten years ago is not available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-268

OUTCOME 4: Aged Care and Population Ageing

Topic: CONTINENCE AIDS PAYMENT SCHEME

Hansard Page: CA 8

Senator Fifield asked:

What is the average postage cost of a client over a year?

Answer:

The cost for each individual client is not collected by the Department.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-227

OUTCOME 4: Aged Care and Population Ageing

Topic: ELDERLY WITH POOR VISION

Written Question on Notice

Senator Adams asked:

a) Are you aware that there is a possibility of increased falls and hip fractures in elderly Australians due to a consequence of poor vision, and due to that there will be an increase in patients to the public health system?
b) What support and funding will be in place for these people?

Answer:

a) The Department is aware of the possibility of increased falls and hip fractures in elderly Australians due to the consequence of poor vision.

b) The Australian Government's National Eye Health Initiative has delivered a range of activities, including eye health demonstration projects and an eye health awareness raising campaign.

The Australian Government, in collaboration with the states and territories, funds several publications to provide guidance on preventing falls.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-267

OUTCOME 4: Ageing and Aged Care

Topic: CONTINENCE AIDS PAYMENT SCHEME

Hansard Page: CA 8

Senator Fifield asked:

How much has the Government saved on postage costs under the new Continence Aids Payment Scheme?

Answer:

The Continence Aids Payment Scheme has not yet commenced. The Scheme is due to commence on 1 July 2010 and will replace the current Continence Aids Assistance Scheme.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-278

OUTCOME 4: Aged Care and Population Ageing

Topic: AGE OF BED ALLOCATIONS

Hansard Page: CA 66

Senator Boyce asked:

Could you give me the number of provisionally allocated places, with a state breakdown, which are more than 12 months old, more than two years old, more than three years old, until we run out of years, so to speak?

Answer:

Please see the table below which sets out by state and territory, the number of provisionally allocated places as at 30 June 2009, and those more than one year old at yearly intervals, up to eight years old.

Table: Age and number of all provisionally allocated places* as at 30 June 2009

State / territory	More than 1 yr old	More than 2 yrs old	More than 3 yrs old	More than 4 yrs old	More than 5 yrs old	More than 6 yrs old	More than 7 yrs old	More than 8 yrs old	More than 9 yrs old
QLD	3,207	1,765	1,149	538	136	70	59	0	0
NSW	5,620	3,800	2,867	1,541	405	80	80	40	0
VIC	2,864	1,861	1,121	637	194	71	66	45	0
TAS	159	100	25	25	25	0	0	0	0
SA	602	308	115	14	0	0	0	0	0
WA	1,394	836	504	334	88	68	60	30	0
NT	65	0	0	0	0	0	0	0	0
ACT	605	438	343	198	32	16	0	0	0
Australia	14,516	9,108	6,124	3,287	880	305	265	115	0

*All provisionally allocated places includes residential, community care and transition care.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-276

OUTCOME 4: Aged Care and Population Ageing

Topic: REGIONAL BREAKDOWN OF AGED CARE APPROVALS ROUND PLACES

Hansard Page: CA 59-60

Senator Siewert asked:

What is the number of places that were applied for versus the number of places that were available by region?

Answer:

Please see Attachment A which sets out for each planning region and each state and territory: the number of aged care places made available; the number of application received; and the number of places sought in those applications, in the 2008-09 Aged Care Approvals Round.

Please note that tables include where applicable, places that were available at the state and territory level that is, places that were not allocated to a specific region within the state.

Attachment A

National/regional response to 2008-09 Aged Care Approvals Round

	Total Places Advertised	Total Applications Received	Total Places Sought
New South Wales	2994	724	15505
Victoria	2096	487	12707
Queensland	3026	395	9643
Western Australia	1544	133	2552
South Australia	288	147	2168
Tasmania	206	82	829
ACT	214	27	494
Northern Territory	79	13	92
Totals	**10447**	**2008**	**43990**

New South Wales (Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Central Coast	130	29	524
Central West	130	18	375
Far North Coast	149	27	563
Hunter	318	89	2354
Illawarra	155	29	393
Inner West	75	35	602
Mid North Coast	205	52	1046
Nepean	250	29	462
New England	35	12	95
Northern Sydney	128	66	1588
Orana Far West	57	9	84
Riverina/Murray	72	41	446
South East Sydney	397	96	2587
South West Sydney	377	90	2080
Southern Highlands	85	36	444
Western Sydney	431	66	1862
Totals	**2994**	**724**	**15505**

Victoria (Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Barwon-South Western	147	48	970
Eastern Metro	450	91	2935
Gippsland	155	21	376
Grampians	110	23	397
Hume	77	37	548
Loddon-Mallee	178	40	944
Northern Metro	278	81	2049
Southern Metro	318	87	2875
Western Metro	257	59	1613
At the state level	126*		
Totals	**2096**	**487**	**12707**

*A 'pool' of 126 aged care places was made available at the state level for distribution to all aged care planning regions in Victoria focusing on places for restructuring purposes.

Queensland-(Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Brisbane North	120	47	933
Brisbane South	320	73	2009
Cabool	120	15	624
Central West	0*	0	0
Darling Downs	125	20	420
Far North	91	16	374
Fitzroy	120	10	121
Logan River Valley	190	26	689
Mackay	135	8	211
Northern	120	21	269
North West	0*	2	16
South Coast	500	66	41386
South West	0*	0	0
Sunshine Coast	540	51	1154
West Moreton	220	12	459
Wide Bay	230	28	629
At the state level	156*		
Totals	**3026**	**395**	**9643**

*A 'pool' of 156 aged care places was made available to all aged care planning regions in Queensland with a focus on special needs groups; this pool was also made available to potential applicants in the Central West, North West and South West aged care planning regions of Queensland which, while being above the benchmark ratio for both residential and community service provision, given the size of the regions, may have been subject to applications to address availability at the local level.

Western Australia (Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Goldfields	185	18	142
Great Southern			
Kimberley			
Mid West			
Pilbara			
Wheatbelt			
Metro East	180	10	348
Metro North	320	42	894
Metro South East	125	10	192
Metro South West	386	29	642
South West	80	5	49
At the state level	268*		
Totals	**1544**	**123**	**2552**

*A 'pool' of 268 aged care places was made available for distribution at the state level to aged care planning regions in Western Australia largely to address the needs of people from special needs groups.

South Australia (Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Eyre Peninsula	0	1	5
Hills, Mallee and Southern	22	24	155
Metro East	0	0	0
Metro North	113	43	1061
Metro South	35	42	377
Metro West	88	14	316
Mid North	0	1	0
Riverland	11	9	55
South East	0	0	0
Whyalla, Flinders and Far North	0	2	10
Yorke, Lower North and Barossa	0	9	79
At the state level	10*	2	20
Totals	**288**	**147**	**2168**

* A 'pool' of 10 aged care places was made available at the state level for allocation to all metropolitan aged care planning regions in South Australia with a specific focus on the provision of care for people from Aboriginal and Torres Strait Islander communities

Tasmania (Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Northern	33	35	252
North Western	68	7	49
Southern	105	40	528
Totals	**206**	**82**	**829**

Australian Capital Territory (Yellow highlight indicates metropolitan regions)

	Total Places Advertised	Total Applications Received	Total Places Sought
Totals	**214**	**27**	**494**

Northern Territory

(Note: The whole of Northern Territory is regarded as 'regional, rural and remote')

	Total Places Advertised	Total Applications Received	Total Places Sought
Alice Springs	14	3	20
Darwin	14	3	35
East Arnhem	6	2	16
Katherine	6	5	21
At the territory level	39*	0	0
Totals	**79**	**13**	**92**

* A 'pool' of 39 aged care places was made available at the territory level for distribution to all aged care planning regions in Northern Territory.

Australian Government

Department of Health and Ageing

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphery

Request for Amendment to Evidence Provided at the Community Affairs Legislation Committee Hearing,
4 June 2009: Outcome 4 Aged Care and Population Ageing.

I am writing to correct statements that I made at the Budget Estimates of the Senate Community Affairs Committee on 4 June 2009.

Statement 1 ***(Hansard Reference CA6)***
Senator Fifield asked the following question: "How long have they been the sole provider?"

My response was as follows: "Since, I believe 2005, when they won the contract in an open tender process."

In the course of preparing for the Supplementary Budget Estimates hearing it came to my attention that I inadvertently misled the Committee. Intouch has been the sole provider since 1997. They again successfully won the contract through an open tender process in 2005.

Statement 2 ***(Hansard Reference CA6)***
Senator Fifield asked the following question: "What were the administrative costs for the scheme, if you have them for 2007-08, 2008-09 and 2009-10?"

My response was as follows: "The current financial year contract amount is around $32.4m and a significant component of the program allocation goes to products, and so the $479 is for clients. There is a component of approximately $7m in the program administration costs, but that includes freight costs and costs to the provider for salaries, running a call centre, running a website, mailing and updating the product catalogue. There are a range of activities that the provider undertakes in terms of administration of the current scheme on our behalf."

In the course of preparing for Estimates, I realised that I may have inadvertently misled the Senate Committee. The current financial year contract amount is around $32.4m and a significant component of the program allocation goes to products, and so the $479 is for clients. There is a component of approximately $7m in the program administration costs, but that includes costs to the provider for salaries, running a call centre, running a website, mailing and updating the product catalogue. There are a range of activities that the provider undertakes in terms of administration of the current scheme on our behalf."

Yours sincerely

Melinda Bromley
Assistant Secretary
Office for an Ageing Australia
19 October 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-326

OUTCOME 5: Primary Care

Topic: General Practice Training Locations

Hansard Page: CA 139

Senator Boyce asked:

Are you able to give me, on notice, a geographical location of where your trainees are?

Answer:

AGPT program trainees were located in all states and territories across Australia. Tabulated below is a distinct count of registrars which incorporates movements between training locations over a training year. The geographic location is illustrated by state/territory and RRMA classification , with totals indicating the actual number of registrars in training in that location for the 2008 training year.

RRMA State	1 DistCount registrars	2 DistCount registrars	3 DistCount registrars	4 DistCount registrars	5 DistCount registrars	6 DistCount registrars	7 DistCount registrars	Total
ACT	32							32
NSW	283	201	83	154	143	1	5	694
NT	30		11	9	4	26	8	70
QLD	170	55	94	85	99	20	23	445
SA	130			35	66	2	7	194
TAS	30		5	15	25			62
VIC	264	12	28	148	176		3	492
WA	131	8		45	26	20	25	193
Total	1069	276	220	483	536	70	73	2131

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09:327

OUTCOME 5: Primary Care

Topic: General Practice Training in Indigenous Health

Hansard Page: CA 139

Senator Boyce asked:

GPET is setting targets for indigenous health training. Again, could I have a list of where those trainees are located, where the training places are located, or whatever is a useful way to describe those?

Answer:

AGPT program trainees were located in all states and territories across Australia. Tabulated below is a distinct count of registrars which incorporates movements between Aboriginal Medical Services locations over a training year. The geographic location is illustrated by state/territory and RRMA classification, with totals indicating the actual number of registrars in training in that location for the 2008 training year.

RRMA	1	2	3	4	5	6	7	Total
State	DistCount registrars	DistCount registrars	DistCount registrars	DistCount registrars	DistCount registrars	DistCount registrars	DistCount registrars	
ACT	1							1
NSW	6	5		12	3		1	27
NT				9		15	7	29
QLD	2		5		6	2	10	21
SA	5			7				8
TAS	1							1
VIC	4			6	3		1	14
WA				1	1	14	18	21
Total	19	5	5	35	13	31	37	121

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-328

OUTCOME 5: Primary Care

Topic: General Practice Training in Indigenous Health

Hansard Page : CA 140

Senator Boyce asked

Getting back to the degree of difficulty in sourcing people to do the indigenous health training, how many actual individuals are we talking about? How many registrars are training in the indigenous health area?

Answer:

121 AGPT program trainees were training within an Aboriginal Medical Service during 2008. An additional 705 trainees had undertaking an indigenous health activity during 2008.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-021

OUTCOME 5: Primary Care

Topic: GENERAL PRACTITIONERS

Written Question on Notice

Senator Ryan asked:

a) Does the Department collect or maintain data pertaining to the spatial distribution of General Practitioners by postcode or local government areas?
b) If so, what are the current data in each state and territory?

Answer:

a) Yes, the Department maintains data pertaining to the spatial distribution of General Practitioners (GP) at both the postcode and local government areas.

GP workforce figures are currently only released for Divisions of General Practice, by State and Nationally. These figures are published on the Department's website at http://www.health.gov.au/internet/main/publishing.nsf/Content/General+Practice+Statistics-1

b) The figures in Table 1 below show the most recent data available on GP headcount figures by State for 2007-08.

Table 1: General Practitioner Headcount by State 2007-08 (latest figures available)

NSW	VIC	QLD	SA	WA	TAS	NT	ACT
7,948	6,057	5,051	2,100	2,359	660	345	383

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-022

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Written Question on Notice

Senator Ryan asked:

How many doctors have (i) expressed interest, and/or (ii) contracted to a GP superclinic:
a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?

Answer:

a – h)
(i) and (ii)
The Australian Government will not own or operate the GP Super Clinics and as such the GP Super Clinic operator is responsible for all operational and employment matters, including receiving expressions of interest to work in a clinic or contracting doctors to the clinic.

The Department is however able to advise that a number of doctors and allied health professionals have expressed interest in working in a GP Super Clinic as evidenced by telephone calls to the Department and correspondence received through the GP Super Clinics email address. In addition, the Department is aware that doctors have been employed in two of the clinics – Blue Mountains (NSW) and Ballan (VIC) - to provide interim services in advance of construction being completed.

A GP Super Clinic will not be established in the Australian Capital Territory.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-023

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Written Question on Notice

Senator Ryan asked:

a) What packages, bonuses or other incentives are being given or offered to doctors to attract interest in GP superclinics?
b) What is the total cost of these incentives?
c) What proportion of the total budget for the GP superclinics does this represent?
d) Is the cost of these incentives included in the total budget for the GP Superclinic program?

Answer:

a – d)

The Australian Government will not own or operate the GP Super Clinics and as such the GP Super Clinic operator is responsible for determining whether packages, bonuses or other incentives will be offered. The Department is therefore unable to provide the details sought.

However, the GP Super Clinics Program does provide for relocation incentives under certain circumstances (eg. only for health professionals relocating during the first 12 months of the GP Super Clinic's operation), and where this is applied for by the funding recipient. The National Program Guide provides details (pages 21-23).

The maximum amount of funding available on a per capita basis for the Program's relocation incentives is $15,000 for GPs; $7,500 for allied health professionals; and $6,000 for nurses, mental health workers and Aboriginal and Torres Strait Islander health workers. A sum of $7,500 per location is available for relocated pharmacy/pharmacist services.

It is not possible to identify the total cost of the Program's relocation incentives, since this will depend on how many health professionals are recruited and whether the conditions for payment (eg 12 months of service at the GP Super Clinic) are met.

The cost of the Program's relocation incentives is included in the total budget for the GP Super Clinic program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-024

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Written Question on Notice

Senator Ryan asked:

How many GP superclinics have opened for business as at May 12 2009?

Answer:

Ballan (Victoria) and Blue Mountains (NSW) had commenced provision of interim services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-025

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Written Question on Notice

Senator Ryan asked:

How many general practitioners who have taken a position in a GP superclinic were previously working as general practitioners in the same town/city/region?

Answer:

All employment matters, including recruitment of general practitioners, are the responsibility of the operator of the GP Super Clinic.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-034

OUTCOME 5: Primary Care

Topic: DOCTOR NUMBERS

Written Question on Notice

Senator Ryan asked:

a) Does the Department have a desired number of doctors (as determined per measure of population) for Australia? Does it have different targets for various cities and regions?
b) If so, what are these targets?
c) Are there variations between different regions?
d) If so, what is the justification for these variations?
e) What areas are not meeting these targets?

Answer:

a – e)

The Department does not have a desired number of doctors as determined by population for Australia. In order to achieve an equitable distribution of medical services across Australia, the Department uses a doctor to population ratio in determining which regions have district of workforce shortage (DWS) status.

DWS is determined by using both Australian Bureau of Statistics population data and Medicare Australia's billing data.

A DWS is calculated by comparing an area's ratio of population to full time equivalent (FTE) general practitioners with that of the national average.

In general, a location is deemed to be a DWS if it falls below the national average for the provision of medical services. Population needs for health care are deemed to be unmet if a district has less access to medical services than the national average.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-176

OUTCOME 5: Primary Care

Topic: THE PRACTICE INCENTIVES PROGRAM (PIP) eHEALTH INCENTIVE

Hansard Page: CA 138

Senator Boyce asked:

Would you be able to tell me, say by state, where those practices [which have signed up for the PIP eHealth Incentive] are? I am interested in whether there are any trends in early adopting.

Answer:

Detailed information will not be available until processing of the applications is completed, which is expected to be in mid-August 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-177

OUTCOME 5: Primary Care

Topic: GP ASSIST

Hansard Page: CA 132

Senator Cormann asked:

Once discussion in regard to GP Assist has happened can the Department please provide further information to the Committee.

Answer:

In consultation with GP Assist, the Department commissioned an independent consultant to review the business case provided by GP Assist to maintain the service in its current form. The review found that there is a need for further consideration on the interface issues between GP Assist and *healthdirect Australia.* On this basis, the Department has decided to vary the current funding agreement with GP Assist extending it to 30 June 2011. The varied agreement will be substantially under the same terms as the original GP Assist 2008-2010 funding agreement with an additional year of funding provided for the 2010-2011 financial year. Nonetheless, the Commonwealth policy to not fund duplicate nurse triage services in the longer term in areas where *healthdirect* is operating has not changed and reference to the transition has been retained in the funding agreement. The agreement to fund GP Assist to June 2011 will enable the Department to give further consideration to the interface issues between GP Assist and *healthdirect Australia*.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-228

OUTCOME 5: Primary Care

Topic: SERVICE MODEL TRIALS

Written Question on Notice

Senator Adams asked:

Does the Department agree that when new health service models are to be trialled, they would be best started in regional or rural areas so as not to further exacerbate the difference in access to services (If a new service is developed in the city or the regional centre and it is successful, it may well attract staff at a time when there are serious shortages in smaller towns).

Answer:

No. Trials are undertaken for a variety of different reasons and purposes. Sometimes those trials will be relevant to and practical to implement in regional and rural areas. However, this is not always the case. The recently announced changes to rural health workforce programs are intended to improve incentives for doctors to practise in rural and regional Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-229

OUTCOME 5: Primary Care

Topic: GP SUPER CLINICS

Written Question on Notice

Senator Adams asked:

e) Is there a danger that GP Super Clinics will attract health professionals from more needy areas?

f) Has any modelling being done on this possibility?

Answer:

a) GP Super Clinics will provide additional resources in communities with demonstrated needs. In identifying these communities there were a range of factors taken into account:
   - High levels of chronic disease and/or communities with high needs, such as large numbers of children or elderly;
   - Poor access to services – particularly GP shortages and Medicare services;
   - Poor health infrastructure; and
   - Levels of demand on the emergency department of the local hospital that could be reduced by the introduction of preventative health care services.

b) No. GPs, allied health professionals, nurses and pharmacists currently working in an area of need or a District of Workforce Shortage (where this is applicable to their profession), are not eligible for the relocation incentives that can be paid under the program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-096

OUTCOME 5: Primary Care

Topic: PREGNANCY COUNSELLING

Written Question on Notice

Senator Hanson-Young asked:

Page 206 of the Department of Health Portfolio Budget Statement states "The Department will also commence work to enhance existing telephone and internet health information services to provide help and advice about pregnancy related matters from July 2010". This will include the introduction of phone referrals to a range of other specialised support services such as peer breastfeeding advice and grief and loss support.

a) What issues will the phone service provide referrals for?
b) What service providers will the phone service refer to in each state?
c) How will this be decided?
d) Will this include termination services?
e) If not, why not?
f) Will the expansion of the telephone service go out to tender or will it go straight to McKesson, who have the current contract?

Answer:

a) The helpline will become a coordinated entry point for people seeking a broad range of advice and information related to pregnancy and the first 12 months after the birth of a child; including information on other maternity related services including specialist and support services.

   Where requested by a caller, the helpline will provide contact information for clinical and non-clinical services relevant to all aspects of pregnancy and the first 12 months of a baby's life.

b) The helpline will be supported by a service directory containing location and contact details for a range of services, including those that are available in the caller's local area. The service directory will include clinical and non-clinical services relevant to all aspects of pregnancy and the first 12 months of a baby's life and will be used to direct callers to appropriate services to meet their needs.

c) Specific service categories to be included in the service directory will be determined by the Department in the detailed planning work to be undertaken prior to 1 July 2010.

d) From 1 July 2010, the helpline's counsellors will be able to provide contact information for adoption and termination services. Contact information for adoption or termination services will only be provided when specifically requested by a caller, once the counsellor is confident the caller is aware of all the available pregnancy options. This is one of a number of service enhancements that will be implemented from 1 July 2010.

e) Not applicable.

f) The Australian Government will provide funding to National Health Call Centre Network Ltd (NHCCN Ltd), the management vehicle with responsibility for establishing and managing the National Health Call Centre Network. NHCCN Ltd will be responsible for procuring a call centre service provider to deliver the helpline from 1 July 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-308

OUTCOME: 5: Primary Care

Topic: GP SUPER CLINICS

Hansard Page: CA 133

Senator Cormann asked:

If you could provide us, essentially, with a status update for each of the 31 sites, where things are now at and what is now your target for them to become fully operational, that would be fantastic.

Answer:

The following status report reflects the situation as at 29 September 2009. As 'fully operational' is not a formal milestone under the funding agreement, we have provided timeframes for 'practical completion', which requires building works to be complete and services to have commenced. These are approximate time frames as timely completion of construction is heavily dependent on external factors, including local council building planning and approval processes, availability of construction workforce, materials and weather conditions.

Location		**Status**
VIC	Ballan	Funding agreement executed (30 June 2008). Early services commenced March 2009. Clinic opened in mid Sep 2009.
	Bendigo	Funding agreement executed (30 June 2008). Practical completion anticipated by early 2011.
	Berwick	Funding agreement not yet executed.
	Geelong	Funding agreement executed (4 March 2009). Practical completion anticipated by late 2010.
	Portland	Funding agreement not yet executed.
	South Morang	Funding agreement not yet executed.
	Wodonga	Funding agreement not yet executed.
	Wallan	Funding agreement not yet executed.
QLD	Brisbane Southside	Funding agreement not yet executed.
	Bundaberg	Funding agreement not yet executed.
	Cairns	Funding agreement executed (20 May 2009). Practical completion anticipated by mid/late 2011.
	Gladstone	Funding agreement not yet executed.
	Ipswich	Funding agreement executed (26 June 2009). Practical completion anticipated by early 2012.
	Mt Isa	Funding agreement executed (25 June 2009).

		Practical completion anticipated by mid/late 2011.
	Redcliffe	Funding agreement executed (27 January 2009). Practical completion anticipated by mid 2011.
	Strathpine	Funding agreement executed (16 April 2009). Building works commenced. Practical completion anticipated by mid/late 2010.
	Townsville	Funding agreement executed (21 May 2009). Practical completion anticipated by mid/late 2011.
NSW	Blue Mountains	Funding agreement executed (23 January 2009). Early commencement of services from existing facilities. Practical completion anticipated by late 2010.
	Grafton	Funding agreement executed (25 June 2009). Practical completion anticipated by mid/late 2011.
	North Central Coast	Funding agreement executed (15 April 2009). Early commencement of services from existing facilities. Practical completion anticipated by early 2012.
	Port Stephens	Funding agreement executed (3 February 2009). Practical completion anticipated by late 2010.
	Riverina	Funding agreement executed (3 August 2009). Practical completion anticipated by mid 2011.
	Shellharbour	Funding agreement executed (3 February 2009). Practical completion anticipated by early 2011.
	Southern Lake Macquarie	Funding agreement executed (29 January 2009). Early commencement of services from existing medical centre. Practical completion anticipated by late 2010.
	Queanbeyan	Funding agreement executed (26 June 2009). Practical completion anticipated by late 2011.
TAS	Burnie	Funding agreement executed (17 April 2009). Practical completion anticipated by late 2010.
	Clarence [Hobart Eastern Shores – Site A]	Funding agreement executed (16 January 2009). Practical completion anticipated by late 2010.
	Devonport	Funding agreement executed (9 April 2009). Early services commenced from existing facilities. Practical completion anticipated by mid 2010.
	Sorell [Hobart Eastern Shores – Site B]	Funding agreement executed (21 April 2009). Practical completion anticipated by late 2010.
NT	Palmerston	Funding agreement executed (22 April 2009). Urgent care after hours service (operated by Northern Territory Government) commenced in December 2008. Building works commenced. Practical completion anticipated by late 2010.
WA	Cockburn	Funding agreement not yet executed.
	Midland	Funding agreement executed (31 July 2009). Practical completion anticipated by early 2011.
	Wanneroo	Funding agreement not yet executed.
SA	Modbury	Funding agreement executed (29 July 2009). Practical completion anticipated by late 2011.
	Onkaparinga (Noarlunga)	Funding agreement executed (29 July 2009). Practical completion anticipated by late 2011.
	Playford North	Funding agreement executed (29 July 2009). Practical completion anticipated by mid/late 2011.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-334

OUTCOME 6: Rural Health

Topic: RURAL WOMEN'S GENERAL PRACTICE SERVICE (RWAPS)

Hansard Page: CA 145

Senator Adams asked:

Has the number of actual participants, the number of women being seen, within the Rural Women's GP Service increased?

Answer:

Yes.

In the 12 month period 1 July 2006 to 30 June 2007, 16,094 people, of whom 15,376 were women, consulted with a female GP through the RWGPS.

In the 12 month period 1 July 2007 to 30 June 2008 17,174 people, of whom 16,466 were women, consulted with a female GP through the RWGPS.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-099

OUTCOME 7: Hearing Services

Topic: HEARING SERVICES

Written Question on Notice

Senator Back asked:

I understand that measures are being undertaken to address the underlying health issues but measures are there to assist those who are already suffering from hearing difficulties?

Answer:

The Office of Hearing Services manages the Government's Hearing Services Program which provides eligible Australians and permanent residents with free hearing services, including hearing assessment, hearing rehabilitation and the fitting of hearing devices, if appropriate.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-100

OUTCOME 7: Hearing Services

Topic: HEAR AND LEARN

Written Question on Notice

Senator Back asked:

Are you aware of the work of Hear and Learn, the Australian distributor of LightSPEED hearing technology which has been determined by National Acoustic Laboratories (a division of Australian hearing) which concluded in 2003 that "this study supports the use of sound field amplification to advance the acquisition of literacy and numeracy skills for children in mainstream classrooms, and not only for those children with identified hearing loss or with 'English as a second language' backgrounds"?

Answer:

Hear and Learn is the Australian distributor of a brand of sound-field amplification systems. The Office of Hearing Services is aware of the 2003 study carried out by the National Acoustic Laboratories.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-152

OUTCOME 8: Indigenous Health

Topic: ASBESTOS ISSUES AND KATUNGUL ABORIGINAL COMMUNITY CORPORATION & MEDICAL SERVICE

Hansard Page: CA27

Senator Payne asked:

An occupational hygienist has recently visited Wallaga Lake undertaking testing of both ambient air and soil samples. Who sent the occupational hygienist?

Answer:

The New South Wales Department of Health organised for the occupational hygienist.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-154

OUTCOME 8: Indigenous Health

Topic: FOETAL ALCOHOL SYNDROME (FAS)

Hansard Page: CA46

Senator Adams asked:

Regarding the Northern Territory emergency response, with paediatricians moving through the communities. Have any communities within the 73 prescribed communities had this problem?

Answer:

Screening for Foetal Alcohol Syndrome was not included in the Child Health Checks data collection as there is no nationally agreed screening tool available for this syndrome.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-097

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS EYE AND EAR HEALTH

Written Question on Notice

Senator Back asked:

Recent budget initiatives recognise that eye and ear health remain an urgent health area in indigenous populations. I am aware that $58.3 million have been allocated. Can you advise what measures are being implemented through this recent funding? Or how this funding will be allocated?

Answer:

A total of $58.3 million has been allocated for the *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes* measure over four years commencing in July 2009. This initiative seeks to address barriers to Indigenous people accessing eye and ear health care, particularly in remote and rural areas.

The *Improving Eye and Ear Health Services for Indigenous Australians for Better Education and Employment Outcomes* measure will involve expansion of the Visiting Optometrist Scheme; increased services to address trachoma; training of health workers for hearing screening; maintenance and purchase of medical equipment for hearing screening; additional ear and eye surgery; and hearing health promotion.

Implementation strategies are being developed in consultation with key stakeholders, including state and territory governments and experts in the fields of eye and ear health. The first phase of the initiative has involved the organisation of two Clinical Roundtables in Eye and Hearing Health, to determine best practice approaches for the delivery of eye and hearing services to Indigenous Australians. Strategies agreed to by key stakeholders will inform the allocation of funds.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-098

OUTCOME: 8: Indigenous Health

Topic: HEARING FOR INDIGENOUS STUDENTS

Written Question on Notice

Senator Back asked:

How significant a problem is hearing for Indigenous students?

Answer:

Rates of ear disease (otitis media) and hearing problems for Indigenous children are higher than those of the non-Indigenous population. Otitis media is infection and inflammation of the middle ear space and eardrum. Symptoms include earache, fever and in some cases, diminished hearing. Data8 from the Aboriginal and Torres Strait Islander Health Performance Framework Report 2008 indicates that:

- In 2004–05, approximately 10% of Indigenous children aged 0–14 years reported having ear or hearing problems compared with 3% of non-Indigenous children of the same age. Prevalence rates for ear/hearing problems were 95 per 1,000 population among Indigenous children and 30 per 1,000 population among non-Indigenous children.

- Diseases of the ear and mastoid were more prevalent among Indigenous children aged 5–14 years (12%) than among Indigenous children aged 0–4 years (6%).

- Complete or partial deafness/ hearing loss and otitis media were both more prevalent among Indigenous children than among non-Indigenous children. Approximately 5% of Indigenous children aged 0–14 years reported complete or partial hearing loss or deafness compared with 1% of non-Indigenous children. Approximately 4% of Indigenous children of the same age reported otitis media compared with 2% of non-Indigenous children.

Hearing problems are commonly linked to poor school attendance and educational outcomes. The early onset of middle ear infection and inflammation, which results in fluctuating hearing loss, reduces active participation in education and may limit future employment opportunities.

8 Source: ABS and AIHW analysis of 2004-05 National Aboriginal and Torres Strait Islander Health Survey

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-109

OUTCOME 8: Indigenous Health

Topic: OATSIH's PERFORMANCE

Written Question on Notice

Senator Payne asked:

a) Has OATSIH's performance or outcomes ever been independently reviewed?

b) If not, why not?

Answer:

a) Over the last 7 years, a number of reviews of the performance and outcomes of OATSIH and related Departmental programs have been conducted by expert groups and individuals, as well as by the Australian National Audit Office (ANAO) and the Office of Evaluation and Audit – Indigenous Programs (OEA-IP), including:

Expert Review:

- 2002 - Review of the Commonwealth Funded Hearing Services to Aboriginal and Torres Strait Islander People; http://www.health.gov.au/internet/main/publishing.nsf/Content/health-hear-client14.htm/$FILE/hsatsips.pdf

- 2003 – Review of the Australian Government's Aboriginal and Torres Strait Islander Primary Health Care Program (7-volume report); http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-reviewphc.htm

- 2003 – Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program; http://crh.flinders.edu.au/research/eyehealthreview.pdf

- 2006 – Report on Aboriginal and Torres Strait Islander Access to Major Health Programs; http://www.medicare.gov.au/public/services/indigenous/files/aboriginal_torres_strait_islander_access_to_major_health_programs.pdf

- 2008 – Report on the Aboriginal and Torres Strait Islander National Health Performance Framework; http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-framereport

- 2008 – Report on the link between primary health care and health care outcomes for Aboriginal and Torres Strait Islander Australians; http://www.health.gov.au/internet/main/publishing.nsf/Content/health-oatsih-pubs-linkphc

ANAO audits and evaluations:
ANAO audits are aimed at different aspects of Government Departmental management practices. In some cases they are directly relevant to OATSIH's health program, in others OATSIH's processes have been examined as part of an agency wide audit.

- 2002 - ANAO follow-up audit of the Aboriginal and Torres Strait Islander Health Program; http://www.anao.gov.au/uploads/documents/2002-03_Audit_Report_15.pdf

- 2007 – Whole of Government Indigenous Service Delivery Arrangements (one of 4 agencies involved); http://www.anao.gov.au/uploads/documents/2007-08_Audit_Report_101.pdf

OEA Audits and Evaluations:
OEA, formerly part of the Aboriginal and Torres Strait Islander Commission and now in the Department of Finance and Deregulation, provides objective advice to the Australian Government on the management and performance of its Indigenous-specific programs.

- 2006 – Audit of Primary Health Care Funding to Aboriginal Community Controlled Health Services;

- 2008 – Evaluation of the OATSIH Primary Health Care Funding programs (finalisation pending).

b) Not applicable – see answer to (a) above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-`

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Payne asked:

When an Aboriginal Medical Service submits an application for funding, does OATSIH have a benchmark or guaranteed response time?

Answer:

The majority of recurrent funding to OATSIH funded Aboriginal Medical Services is rolled over annually for organisations that comply with the annual funding requirements.

If the Aboriginal Medical Service has submitted a funding application in response to OATSIH's invitation for submission, the application is assessed in accordance with the specific criteria applicable to that funding. Such as for Healthy for Life (Attachment A) and Urban Brokerage (Attachment B).

If the Aboriginal Medical Service has submitted an unsolicited application for funding, it is assessed on its merit, in accordance with government priorities and availability of funds.

The response time depends on the criteria for assessing the application and what further information may be required, when it is received and in some cases when funds become available.

Healthy for Life

healthy for life.
Healthy Life. Healthy Community.

Funding Round Three

PHASE 1
APPLICATION GUIDELINES

TABLE OF CONTENTS

This Guide to applying forms part of the Application Kit.

The Guide contains information and advice on:

Section One – *Healthy for Life* Program and Funding

Background on the *Healthy for Life* Program
Overview of the Program
Who can apply?
- This section outlines who is eligible, how many services will be funded, how your application will be assessed, and expected timing for this process.

Funding Available
Requirements of the Program
Evaluation of the Program
Where can I get more information?

Section Two - Completing Your Application

A. Organisational Details
B. Meeting the Program Eligibility Criteria
C. Information about your current service activity
D. Implementation of Phase 1 Activities- Knowing Your Starting Point
E. Budget
F. Declaration (Single or Lead Organisations)
G. Declaration - Consortium members
H. Consortium/Partnership applicant details (if applicable)

Section Three – Where to submit your application – how, when, where

Section Four – Application Checklist

Closing Details
The call for applications will close at:

2pm (Eastern Standard Time) on Thursday 9th October 2008.

Privacy and Freedom of Information
The information in this application kit will be used for assessing your proposal. The Australian Government will not use this information for any other purpose and will not disclose it without consent.

The provisions of the *Freedom of Information Act 1982* apply to documents in the possession of the Australian Government.

Section 1: *Healthy for Life* Program

1.1 Background

The *Healthy for Life* program was established in 2005/06. The program aims to enhance the capacity of Aboriginal and Torres Strait Islander primary health care services9 to improve the quality of child and maternal health services, men's health and chronic disease care, and over time to reduce the incidence of adult chronic disease in Indigenous communities.

The **objectives** of *Healthy for Life* are to:

1. improve the availability and quality of child and maternal health care;
2. improve the prevention, early detection and management of chronic disease;
3. improve men's health;
4. increase the capacity of the Aboriginal and Torres Strait Islander health workforce by increasing the number of health scholarships available to Aboriginal and Torres Strait Islander people through the Puggy Hunter Memorial Scholarship Scheme; and
5. improve long term health outcomes for Aboriginal and Torres Strait Islander Australians.

The expected outcomes in the short to medium term (1–4 years) are:

- increase in first attendance for antenatal care in first trimester,
- 10% increase per year of adult and child health checks,
- 30% improvement in best practice service delivery for people with chronic conditions, and
- increased number of scholarship recipients.

The expected outcomes in the longer term (5-10 years) are:

- increase in mean birth weight to within 200g of non-Indigenous population,
- decrease in incidence of low birth weight by 10%,
- reduction in selected behavioural risk factors in pregnancy by 10%,
- 30% reduction in hospital admissions for chronic disease complications, and
- 30% improvement in numbers of patients with intermediate health outcomes within acceptable range.

Healthy for Life's program design is based on delivering population health approaches in a primary health care context using quality improvement principles, processes and tools.
Recent developments include adding men's health as one of the objectives of the program.

Over 83 primary health care services are participating in the program through 53 sites. Approximately 79% of primary health care services funded through Healthy for Life to date are located in regional and remote areas, and over 30 services are in areas with little or no Australian Government provided health service.

It is acknowledged there is significant unmet need in urban areas, where greater numbers of Aboriginal and Torres Strait Islander children live. On 4 July 2008 Minister Roxon approved the removal of the regional/remote benchmark of 80% of services and the incorporation of men's health in *Healthy for Life.*

The inclusion of men's health as a focus within *Healthy for Life* supports the Government's commitment to develop a National Men's Health Policy. Organisations entering the program in 2008/09 can choose to address men's health issues in addition to or in conjunction with chronic

9 For *Healthy for Life* purposes, "Aboriginal and Torres Strait Islander primary health care services" refers to Aboriginal Community Controlled Health Services and other primary health care services that deliver health care to predominantly Aboriginal and Torres Strait Islander populations.

disease and child and maternal health. For example, services may wish to implement chronic disease prevention programs targeting Indigenous men, or programs that involve men in their partner's pregnancy. Round 3 *Healthy for Life* services can identify men's health issues as a gap in the service stock take undertaken in Phase 1 and incorporate strategies in the Phase 2 proposal and action plan. All *Healthy for Life* services must address child and maternal health and chronic disease issues. In addition, services may include a focus on men's health.

Healthy for Life is complementary to *New Directions: An Equal Start in Life for Indigenous Children – Child and Maternal Health Services* as it builds on existing Aboriginal and Torres Strait Islander specific and mainstream primary health care services for Aboriginal and Torres Strait Islander people.

1.2 Overview of the Program

Healthy for Life Phase 1 – Knowing your Starting Point

During Phase 1 of *Healthy for Life* the organisations are required to:

a. Gather and analyse baseline information about child and maternal health, and chronic disease (and men's health if appropriate) issues and service-related activity in their own organisation. This information will include:

   - Mapping their current activities and service systems supporting child and maternal health, men's health and the early detection and management of chronic diseases both within the service, and including linkages to other relevant service providers in their region;
   - Using quality improvement tools (eg. process mapping) to develop a shared understanding throughout the organisation of the clients' experience when they enter the health service, i.e. describing the client care processes;
   - Conducting clinical audits through reviewing medical records to determine the key child and maternal health and chronic disease issues affecting the service; and
   - Collecting measurements of 11 specific *Healthy for Life* essential indicators to be used as baseline data for reports and future planning.

   The baseline information helps to identify strengths and gaps in service delivery and priority areas for action required to bring about improvements in the delivery of health services for the community.

   The baseline information also provides a reference point so that organisations are able to monitor their own progress in achieving their objectives for improvement in child and maternal health and the prevention, early detection and management of chronic disease.

b. Use the baseline information to develop a full proposal that outlines an integrated service program, for submission to the Department for approval. The proposal will document the:

- strategic long-term vision of the organisation in the delivery of child and maternal health and chronic disease care and (where appropriate) men's health;
- agreed priority areas for action required to bring about improvement;
- strategies to address the key priorities for action and how the strategies complement current services;
- roles and responsibilities (who will do what);
- how the impact of the strategies will be measured;
- estimated dates for milestones and completion; and
- a detailed budget.

An orientation workshop will be held with successful organisations in the planning and reporting requirements of the program. A 'Service Toolkit' has also been developed for the workshop and later use. Organisations are required to use the OATSIH Service Development and Reporting Framework (SDRF) planning process to develop the full proposal. This SDRF is an action planning tool used by OATSIH-funded organisations in service planning and reporting on achievements to OATSIH.

Organisations are also encouraged to consult with their local Aboriginal and Torres Strait Islander community on the development of their *Healthy for Life* Phase 2 proposal.

Note: Initially organisations will receive funding to undertake and complete Phase 1 – completion of this phase may take up between 3 to 6 months, depending on local circumstances. Organisations who receive Phase 1 funding are eligible to receive Phase 2 funding, subject to completion of Phase 1 activities and meeting the requirements identified in the funding agreement.

Healthy for Life Phase 2 – Service Delivery Begins

Phase 2 involves implementation of the proposal developed during Phase 1.

Upon approval by the Department of the full *Healthy for Life* proposal developed in Phase 1, the funding agreement with OATSIH will be varied to include reference to this *Healthy for Life* proposal as an Implementation schedule. Successful organisations who meet the terms and conditions of the funding agreement and outcomes of the program will be eligible to receive ongoing funding. Funding will be indexed annually.

As part of their Phase 2 activities, successful organisations will be required to monitor and review the baseline information, collected during Phase 1, at least every twelve months and to revise their program plan according to the priorities identified as a result of that review.

1.3. Who can apply ?

Organisations eligible to apply for *Healthy for Life* funding must meet the following criteria:

- Existing incorporated organisations (or a partnership/ consortium of organisations) who deliver primary health care services to a predominantly Aboriginal and/or Torres Strait Islander population;

  OR

- Existing incorporated organisations that are the principal primary health care service for the Aboriginal and/or Torres Strait Islander population in a specific region/locality.

- Existing incorporated organisations that are not rated Extreme, or High Risk according to the OATSIH Risk Assessment Process.

The 2008-09 funding round will be open to government and non-government organisations, with capacity to provide new child and maternal, chronic disease and where appropriate, men's health services.

The types of organisations and agencies that may apply for funding include:

- non-government primary health care providers (including Aboriginal and/or Torres Strait Islander Community Controlled services);
- government funded primary health care providers;
- Divisions of General Practice; and
- Private General practices.

Applicants can be located in regional, remote or urban areas.

Joint Application or a consortium of partnerships may also wish to apply, provided that at least one of these partners meets the above eligibility criteria. Consortia size is limited to a maximum of 5 partner organisations.

Applicants must submit letters of support from the partner organisations and relevant Community Organisations with the completed Application form.

Legal Requirements

For legal and accountability reasons non-government organisations must be incorporated to be eligible for funding.

Applicants should ensure that they are eligible to enter into a Funding Agreement with the Australian Government Department of Health and Ageing before submitting an Application Form. A copy of the Department of Health and Ageing's Standard Funding Agreement is available to be downloaded with this information package. Community controlled health services will be offered an OATSIH Funding Agreement.

How many services will be funded under this Round?

The *Healthy for Life* 2008-09 Round 3 has funding available nationally for approximately 10 – 12 primary healthy care services to undertake Phase 1 activities and Phase 2.

Applications are subject to detailed assessment and selection in accordance with available funds. If your application is short listed and your organisation is not currently funded by OATSIH, you may be contacted to provide additional information.

How will your application be assessed?

Once applications close, they will be prioritised for funding by the Department of Health and Ageing, based on the following criteria:

- the organisation delivers primary health care services to a predominantly Aboriginal and/or Torres Strait Islander population or is the principle primary health care provider for Aboriginal and Torres Strait Islander people in the region;
- Relative need of the Aboriginal and Torres Strait Islander population being serviced;
- Potential for local community support;
- Capacity of the organisation, including ability to meet and sustain the program requirements;
- Level of readiness and understanding of Phase 1 activities; and
- Level of existing funding for chronic disease, child and maternal health care and if appropriate, men's health.

The selection panel will assess the extent to which each application meets the Assessment Criteria and will pay particular attention to Sections C, D and E of the Application Form.

The Department of Health and Ageing may discuss applications with the Aboriginal and Torres Strait Islander Health Forums or expert external agencies in each state and territory to assist the Department in prioritising the applications received. Where this occurs, appropriate confidentiality and conflict-of-interest arrangements will be in place.

Note: applications that do not address all the selection criteria **will not** be assessed.

Seeking further information

The Department of Health and Ageing may request further information from an applicant if it considers that there are any omissions or unintentional errors in the application (for example a missing page). It may also seek further clarification regarding the information provided in the Application Form.

Joint applications

Joint applications will be assessed in a similar manner to those from a single organisation. However, in undertaking the initial compliance check, the application – as a whole – must demonstrate compliance with all eligibility criteria, with a composite/combined assessment of all partners for eligibility, rather than an individual assessment of each partner to the application.

Applications for new *Healthy for Life* services – whether single or joint – will receive a higher prioritisation than existing consortia/partnerships looking to expand.

Timelines for application process

The table below is an indicative timeline for developing and accepting proposals and funding agreements, with implementation to follow:

Activity	Due Date
Application process closes	2pm, 9th October 2008
Assessment of funding applications	October 2008
Announcement of successful service providers	November 2008
Funding Agreements/variations signed with successful service providers	December 2008
Services recruit staff and implement activities	January 2009
Submission of Phase 2 proposals	July - August 2009

Application to continue to Phase 2
On completion of these Phase 1 activities, organisations use the findings of Phase 1 to prepare their *Healthy for Life* proposal which includes an action plan and budget using the guidance and templates to be provided by the Department of Health and Ageing.

Before Applying make sure that you:

- Have read the information provided in the Application kit, including the description of the Program Framework;
- Have checked that your organisation is eligible to apply for funding for *Healthy for Life*;
- Discuss the Program Framework and reporting and evaluation requirement with the Board (or equivalent management authority);
- Have the support of the Board (or an equivalent management authority) to participate in *Healthy for Life*; and
- Have discussed the proposed *Healthy for Life* service with community representatives, and obtained their support in writing.

1.4. Funding Available

What will be funded?

Organisations may seek *Healthy for Life* funding for:

- salaries and on-costs for new/additional staffing;
- travel;
- establishment expenses (see definition below);
- vehicle (1 only) leasing costs10;
- *Healthy for Life* training and staff development and support for Phase 1 and 2 activities provided by a member of the Panel of Quality Improvement Facilitators;
- identified, accredited training specific to child and maternal health and the delivery of chronic disease care and men's health; and
- *Healthy for Life* related administration.

10 In those areas where buying a vehicle represents greater value for money than leasing, vehicle purchase costs may be considered.

Minor establishment expenses

Funding for establishment expenses will be **no more than 10%** of the proposed annual budget.

For the purpose of *Healthy for Life*, minor establishment expenses include:

- Medical equipment required for the provision of chronic disease and child and maternal health care (phase 2 only)*;
- Office furniture and equipment, including computer hardware and software (if required); and
- Short-term office leasing costs associated with short-term additional space requirements.

*Funding for medical equipment **would not** include medical consumables (eg gloves, syringes, tympanometer covers, sharps bins, etc), or TV monitors (except where the equipment is required for the purpose of telemedicine). Funding will not be provided for equipment with insufficient evidence of benefit. Individual medical equipment costing over $10,000 each would need to be itemised and approved separately.

Types of activities that will <u>not</u> be funded

Funding under the *Healthy for Life* program will not extend to the areas listed below:

- major capital works, including refurbishment or purchase of new premises;
- the installation or maintenance of Patient Information and Recall Systems (PIRS);
- projects or activities that duplicate existing resources or initiatives,
- research projects;
- attendance at conferences and seminars, in addition to those provided through *Healthy for Life*; and
- activities which fall outside the jurisdiction of primary health care services (community gardens, childcare services, stand alone/isolated health promotion projects that do not form part of a broader population health program within primary health care, etc).

Amount of Funding available

Funding available for Phase 1 activities will be up to $100,000 for a single organisation and up to $150,000 for a consortium of three or more organisations. Indicative funding levels per site for service delivery under Phase 2 will be up to $400,000 per annum.

The budget must identify staff positions (including skill levels) and the costs associated with undertaking the clinical audit, service and process mapping and systems assessment as well as the development of a proposal for Phase 2 activities.

1.5 Requirements of the Program

Organisations funded through *Healthy for Life* will be required to:

- Obtain Board member (or the equivalent management authority) support to participate in *Healthy for Life*;
- Enter into a standard funding agreement with the Commonwealth, represented by the Department of Health and Ageing (or contract variation where organisations already have an OATISH funding agreement in place) before funds are released;
- Have identified child and maternal health, chronic disease and where appropriate, men's health are identified as priorities for the organisation;
- Undertake a comprehensive systems and medical review as part of Phase 1 of *Healthy for Life*;
- Provide a full project proposal for Phase 2 of *Healthy for Life*, following the completion of Phase 1, for the agreement of the Department of Health and Ageing;
- Participate in the data collection, monitoring and evaluation requirements for the evaluation of the *Healthy for Life* program;
- Provide progress reports on the outcomes achieved through *Healthy for Life* funding, in line with current reporting requirements for OATSIH;
- Make relevant Heal*thy for Life* personnel available to attend and participate in activities related to the ongoing implementation of the *Healthy for Life* program, including but not limited to workshops, meetings and conferences as determined by the Department of Health and Ageing; and
- Participate in the Support, Collection, Analysis and Reporting Function (SCARF) data collection and the *Healthy for Life* evaluation.

Insurance

The Australian Government requirements for insurance are specified in Clause 17 – *Insurance* of the OATSIH Standard Funding Agreement**.**

1.6 Evaluation of Hea*lthy for Life*

Evaluation is an important part of any program. It is aimed at measuring the value and benefits of a project and finding out if there are better ways of doing things.

Evaluation is about:

- Knowing what you have done.
- Finding out how things are done – what has worked and what has not.
- Observing, documenting and measuring changes.
- Seeing what lessons can be learnt.
- Looking at whether the interventions or project offered value for money; and
- Seeing whether the activities should continue.

An evaluation will help to describe what has been done by organisations as part of *Healthy for Life*. It will help draw out the key learning and experience so that these stories can be shared with others.

Evaluation also helps everyone understand what works well, under what conditions, and how things can be improved.

How will the evaluation be done?

There will be two parts to the evaluation.

The first part will be about supporting organisations to collect and analyse data (SCARF) that will show that there has been an improvement, or movement towards an improvement, in addressing the expected *Healthy for Life* outcomes based on 11 essential indicators.

These indicators cover antenatal and maternal health, child health, adult health, chronic disease (diabetes type II and coronary heart disease) and will be submitted either annually (indicators for antenatal and maternal health, child health and adult health) or every six months (diabetes type II and coronary heart disease), as a supplement to existing reporting requirements. Further information on the 11 essential indicators for *Healthy for Life* is located on **www.health.gov.au/healthyforlife.**

This part of the evaluations will begin at the start of the implementation of *Healthy for Life* within funded organisations.

The second part of the evaluation will look at the way *Healthy for Life* has been implemented. It will involve drawing out key learnings and experiences of organisations participating in *Healthy for Life*.

The evaluation will be undertaken in collaboration with the participating organisations, and other key stakeholders. It will be done by an evaluation team who is independent from the Department of Health and Ageing.

When will this begin and how long will it take?

The evaluation will start from the start of the Program and be on-going over the course of *Healthy for Life*. All funded organisations will be required to participate in, and contribute to this evaluation process.

1.7 Where can I get more information?

Further information on the Healthy for Life program and service tool kits are located at **www.health.gov.au/healthyforlife**.

For further information about *Healthy for Life*, and the 2008-09 Round 3 Phase 1 funding process, please contact your nearest OATSIH State and Territory Office *Healthy for Life* contact officer on **1800 787 200** or **healthyforlife@health.gov.au.**

Section 2: Completing your application

The *Healthy for Life* application form is divided into sections.

Part A – Organisation's Details

Where a **single organisation** is applying please provide the applicant details in this first section. Ensure that the contact person (provided in Part A) has authorisation to respond to any questions regarding the application.

If your organisation (excluding government organisations) is not currently funded by OATSIH you will need to provide evidence of your organisation's financial viability such as previous audited financial statements or an audited profit/loss statement for the previous financial year.

In the case of a **joint application,** there must me a specified lead organisation who will be the official auspice for the project and accept overall responsibility for the financial and other reporting and accountability requirements. The lead organisation will also be responsible for the achievement of outcomes.

The lead organisation must be identified as the organisation listed at Part A (Organisation's Details) on the application form. All other consortium/partnerships organisations must complete Part G and H in the Application Form (Consortium/partnership applicant details). In these situations, the applicants must contain evidence that the Board or relevant management of all partner organisation(s) support the application. It is strongly encouraged that organisations in a consortium enter into a Memorandum of Understanding (MOU) which clearly identifies communication, consultation and roles and responsibilities of each member organisation.

Part B – Meeting the Program Eligibility Criteria

Please complete each question and attach (where requested) any relevant documentation to substantiate your responses in Part B.

Defining a 'location of your service'

For the purpose of these guidelines, a locality is a service catchment area, which could be a town or grouping of towns or suburbs within a metropolitan area. Local knowledge is essential in defining catchment areas (Q1.1).

For joint applications, at least one of the partner organisations must meet the eligibility criteria: others may also meet all or some of these criteria.

Each of the questions in Part B is linked to the eligibility requirements for organisations to participate in *Healthy for Life.*

Please attach any letters of support from Aboriginal and Torres Strait Islander community organisations actively supporting this proposal. These letter(s) should indicate that the supporting organisation(s) has reviewed the application and provides in-principle support.

Part C – Information about your current service activity

The Department of Health and Ageing is looking for a range of organisations from remote, regional and urban areas. The Department is also looking for applications from organisations with a range of experience in quality improvement approaches.

Responses in Part C are about the detailed assessment of *relative need* for increased services to Aboriginal and Torres Strait Islander populations and *relative capacity* of the organisation to meet Phase 1, Round 3 *Healthy for Life* program requirements. This section provides applicants with the opportunity to demonstrate the capacity of the organisation to successfully undertake quality improvement activities and to report on the impact of any organisational change and health outcomes. It is these activities that will be built upon in Phase 2 of *Healthy for Life*.

On the application form, question 3.3 asks that you attach evidence that child and maternal health and chronic disease are priorities for your organisation. Men's health may also be identified are priorities for your organisation. Your organisation's Business Plan or Service Development and Reporting Framework Action Plan could show this. These documents describe your organisation's current priorities for service delivery.

Section C in the form requests information on the provision of child and maternal health, men's health and chronic disease. Please include information on your organisation's current programs and activities. It is these programs and activities that will be built upon in Phase 2 of *Healthy for Life*.

Part D – Implementation of Phase 1 Activities- Knowing Your Starting Point

Healthy for Life is implemented in two phases. Part D provides the applicant with the opportunity to explain your initial thinking about *Healthy for Life* Phase 1 activities and your organisation's ***readiness*** for implementing the *Healthy for Life* program in your organisation.

Description of any particular or anticipated challenges for undertaking Phase 1 is also important to the assessment of readiness, and should outline actions for overcoming any significant obstacles.

Please note: A range of resources, tools and support will be available to assist your organisation to undertake Phase 1 and implement *Healthy for Life*. These include access to Quality Improvement Facilitators to assist and guide your organisation in undertaking Phase 1 activities and to upskill staff in quality improvement activities. This support continues in the development of the full Phase 2 proposal and implementation plan for Phase 2 service delivery. Further information on program support is described under 'Program Infrastructure in *Healthy for life – Program Framework'* located on **www.health.gov.au/healthyforlife.**

Financial Viability

The Department is required to assess all organisations' financial viability to receive Australian Government funding. If you are not an existing OATSIH funded organisation, all non-government and private sector organisations must provide one copy of an audited financial statement for the previous financial year OR an audited profit/loss statement for the previous financial year.

Part E – Budget

The following table shows indicative funding to successful applicants:

Site type	Phase 1 funding	Phase 2 funding
Single (small) Organisation	Up to $100,000 (one-off)	Up to $400,000 per financial year
Partnership (1 primary health care service + 1 partner)	Up to $135,000 (one-off)	Up to $540,000 per financial year
Consortium (1 primary health care service + 2 to 4 partners)	Up to $150 000 (one-off) OR $50,000 per primary health care service	Up to $600,000 total per financial year OR $200,000 per financial year, per primary health care service – whichever is the greater per application - capped at 5 primary health care services per application.

Funding for Phase 1 Activities

Funding for Phase 1 activities in Round 3 *Healthy for Life* is to enable organisations to:

- engage a facilitator from the *Healthy for Life* Panel of Quality Improvement Facilitators;
- employ additional staff or 'back fill' existing staff undertaking Phase 1 activities or recruiting (with prior approval from OATSIH) for Phase 2; and
- meet associated administration and minor establishment costs.

Please **COMPLETE** the budget template at **Part E** of the Application form**,** ensuring that GST is calculated separately but is included in the total proposed budget.

Part F– Declaration (Single or Lead Organisations)

Please ensure an authorised representative of the Single or Lead Organisation (as detailed at Part A-Organisation's Details) signs the application by signing the Declaration at Part F.

Part G – Consortium/Partnership applicant details
(Other than Single or Lead organisation listed in Part A, if applicable)

Member applicants of consortia/partnerships have to complete details on their organisation, current service delivery, management, demonstrate priorities in child and maternal health and chronic disease and (where appropriate) men's health, and experience with quality improvement processes.

Part H – Consortium/partnership applicant details (if applicable)

Single or Lead organisations are required to complete **Part A** to **F** of the *Healthy for Life* application form.

Other consortium or partnership organisations are required to complete **Part G** and sign the declaration in **Part H** of the *Healthy for Life* Application form.

Part 4 Application Checklist

Applicants must complete the *Healthy for Life* Application Form to be considered for funding. Before submitting a proposal, applicants need to ensure all necessary information has been provided. The application checklist is located at **Section 4** of the Application Form.

Lead or single organisation applicants must completed **Parts A** to **F** and sign as appropriate **Part F** – Declaration - of the Application Form.

Joint Application - Complete Part G and sign the Declaration included in **Part H**. Submit your application to OATSIH with an accompanying letter of support from the Lead Organisation of the Consortium you are applying to join.

Keep a copy of the completed application for your records.

If you require further information please contact the Department of Health and Ageing by telephoning **1800 787 200,** or email at: **healthyforlife@health.gov.au**

Section 3: Submitting Your Application – When, How and Where

Two (2) unbound copies of the application for *Healthy for Life* funding including supporting documents must be received by:

2pm (Eastern Standard Time) on Thursday 9th October 2008.

Faxed applications **will not** be accepted.

Late applications **will not** be accepted. Extensions **will not** be granted

Where to send you application

Your application should be posted or delivered to the address below:

Physical and Postal Address
Tender Number ITA 050/0809 Tender Box Department of Health and Ageing Ground Floor, Penrhyn House, C Block Bowes Street WODEN ACT 2606

LATE, INCOMPLETE or FAXED applications will not be accepted

Section 4: Checklist

Please complete this checklist before submitting your Application.

Before you begin

- Read all information in these Application Guidelines
- Ensure you understand the assessment criteria for the *Healthy for Life.*
- If you do not already receive funding from OATSIH, read the OATSIH Standard Funding Agreement available to be downloaded with this Application Kit, and understand that by submitting an application, your organisation is agreeing to abide by the terms of this Agreement should you receive funding.

Completing your application

Please ensure that you have included all the information below. If you need further assistance please contact your local OATSIH State/Territory Office or *Healthy for Life* email.

Please check that you have:

- Named the Organisation or Lead Organisation applying for funding.
- Nominated a contact person in this organisation.
- Check that ALL relevant sections of the Application Form are complete.
- Completed and signed the Application Form at Part F – Declaration.

Submit your 2 unbound copies of the Application to the Tender Number ITA 050/0809 Tender Box at the OATSIH Department of Health and Ageing (see Section 3 for instructions).

Supporting Documents

For non-government organisations – (if not already an OATSIH-funded organisation)

- Include one (1) copy of a Certification of Incorporation.
- Include one (1) copy of an audited financial statement for the previous financial year OR an audited profit/loss statement for the previous financial year.

For organisations submitting a Joint Application

- Include any letters of support from Aboriginal and Torres Strait Islander community organisations or other partner organisation/s actively supporting this proposal. These letter(s) should indicate that the partner organisations have reviewed the application and provides in-principle support.
- Include evidence of Community supporting for your application.

Indigenous Community Health Brokerage Services Initiative (sites 3-5)

GUIDELINES

Submission instructions

• You must follow these Guidelines when completing the Application. It is your responsibility to ensure that your Application complies fully with the Guidelines.
• Your Application must include the following (in the one package):
1. An **original** Application that includes:
 Proposed Organisation details - letter of support from partners if joint Application (part one);
 Application for Funding (assessment criteria, implementation plan, reporting requirements, and risk assessment) & letters of support from health service providers who agree to participate in the brokerage service - (part two); and
 Agreement and Declaration Form (part three).
2. Four (4) **unbound** (not stapled) **copies** (Word format, single sided) of the entire Application (ie parts one – three) and supporting documents, and
3. **An electronic copy** of the Application (ie parts one – three) and supporting documents (CD ROM).
• Your Application must arrive at the address designated below by

2.00pm Australian Eastern Daylight Savings Time on Thursday 30 October 2008

Postal address:

ITA – 060/0809
Indigenous Community Health Brokerage Services Initiative
Tender Box
Department of Health and Ageing
Ground Floor
Penrhyn House, C Block
Bowes Street
WODEN ACT 2606

Late, incomplete, faxed or emailed Applications will not be accepted

TABLE OF CONTENTS

SECTION A: GENERAL INFORMATION

These Guidelines relate to the competitive funding process for the remaining three sites under the Indigenous Community Health Brokerage Services Initiative. **Please note that these Guidelines replace those provided for the selection of previous brokerage services.**

This Application seeks details of the proposed brokerage service regarding: the location; how it will lead to an increase of access to both primary health care services and the coordination of follow-up care by a range of primary health care providers; and the level of support from the local Aboriginal and Torres Strait Islander community and health service providers. The proposed brokerage service will also be assessed on its value for money and the organisation's capacity to establish and implement a brokerage service commencing December 2008.

These guidelines provide applicants with the requirements to complete an Application.

1. Background

In 2004, the Council of Australian Governments agreed that there was a need for better engagement by mainstream services in delivering health care to Aboriginal and Torres Strait Islander people.

As part of a larger package in the 2006-07 Budget (*Improving Indigenous Access to Health Care Services)* $12.6 million over four years was allocated to the Indigenous Community Health Brokerage Services Initiative to establish and run five community health brokerage services. The first two brokerage services under this Initiative have been selected. This Application for Funding (AFF) process relates to the selection of the remaining three sites under this Initiative.

2. Funding Objectives

The key objective of this Initiative is to increase access of Aboriginal and Torres Strait Islander people to high quality, culturally appropriate comprehensive primary health care. Brokerage services will increase Aboriginal and Torres Strait Islander peoples' access to mainstream health services by linking people participating in the brokerage service to a network of health care providers. Rather than duplicating existing Indigenous specific health services, the brokerage service will negotiate with providers and community members so that existing services are used to best effect for the Indigenous community, meeting identified needs and finding ways to best meet the gaps in service provision. These brokerage services will operate in urban centres of Australia with a minimum Aboriginal and Torres Strait Islander population of 2,500. The services will provide a sustainable service that offers people participating in the brokerage service cultural security and follow-up and coordination of care to treat and manage chronic disease.

The benefits that will be realised with the provision of brokerage services include **increased**:

• visits to General Practitioners by Aboriginal and Torres Strait Islander peoples within the locality covered by the Brokerage service;

• usage of other allied health services such as podiatrists and dieticians, including referrals through Chronic Disease Management plans;

• usage of state funded primary health services by Aboriginal and Torres Strait Islander people; and

• usage of Medicare Benefit Schedule items particularly:

 Indigenous specific Health Assessment items;

 Chronic Disease Management items; and

 Referrals to allied health professionals for people with chronic conditions and complex care needs.

3. Amount of Funding

As part of the Indigenous Community Health Brokerage Services 2006-07 Initiative $12.6 million over four years was allocated to establish and run five brokerage services. Funding for this Initiative is being allocated through competitive funding processes. Funds for the ongoing operation of individual brokerage services beyond June 2010 will be dependent upon performance of the brokerage service and an overall evaluation of the Initiative.

Organisations that are successful in this Application for Funding process will receive funds to establish and implement a brokerage service. Applicants will need to provide an indicative two year budget for their proposed brokerage service and an implementation plan with timeframes. Applicant's budget should incorporate approximately three months of establishment activities and their associated costs in the 2008/09 financial year. The budget for the remaining four months of the 2008/09 financial year and the subsequent financial year should include operational activities and their associated costs. Applicants are advised to outline where they see that their costings could be unreliable and indicate likely boundaries of their estimate.

For your information successful applicants will have some details of their project (eg project outline, amount of funding and organisation) posted on the Department of Health and Ageing website.

4. What will be funded?

Funding will be provided for the establishment and operation of a brokerage service that meets the conditions of participation and the funding objectives of the Initiative.

5. Type of activities that will not be funded

• Projects or activities that duplicate existing Indigenous specific primary health care services provided in the region;
• Transport of people participating in the brokerage service;
• Direct primary health care service delivery using brokerage funds (including using funds for service delivery in state funded health services); and
• Research projects.

6. Who can apply?

Any organisation can apply to auspice a brokerage service providing it can demonstrate that it can develop an urban brokerage service that meets local Indigenous health needs, overcomes the barriers faced by local Aboriginal and Torres Strait Islander people in accessing mainstream health services and meets the conditions of participation and funding objectives of the Initiative.

For legal and accountability reasons, only bodies specifically incorporated to deliver brokerage services are eligible to receive funding under this Initiative. To avoid any conflict of interest and to support clear and transparent processes, each brokerage service will be required to be established as a separate entity. As such, you are to provide details of the organisation you are proposing to incorporate to deliver these services.

Thus, any organisation can apply in this funding process to auspice a brokerage service or be the lead agency, as long as the proposed brokerage service: will be separately incorporated to deliver brokerage services (ie create a separate entity); aligns with the funding objectives of the Initiative; and meets all of the conditions of participation. You will need to outline arrangements to manage potential conflicts of interest in your Application.

The Department understands that the incorporation process takes time and thus a funding agreement may need to be entered into with an 'auspice' organisation, which would be legally responsible for the project and funds during the initial establishment phase. A new agreement will be entered into once the new body is incorporated.

Applicants should ensure that they are eligible to enter into a Funding Agreement with the Australian Government represented by the Department of Health and Ageing before submitting their Application. A copy of an OATSIH Funding Agreement is available to be downloaded with this information package.

Partnerships between organisations are encouraged. If more than one organisation will be involved in the delivery of a brokerage service, one organisation must be identified as the lead organisation and an authorised representative of this organisation must sign the Application. Letters of support from all other applicants who will be involved in the delivery of the brokerage service will need to be signed by an appropriately authorised person for that organisation (or equivalent) and should be attached to the Application.

7. Conditions of participation

The Application includes three parts.

Part one will outline the details of the organisation(s) applying to deliver the brokerage service and letters of support from partners if a joint Application.

Part two (the Application for Funding) is where the applicant describes the proposed brokerage service and in doing this will need to: address the assessment criteria; include an implementation plan, address the reporting requirements; and include a risk assessment plan.

The assessment criteria to be used by the selection panel when assessing Applications are:

Assessment Criterion One*: Proposed location of the brokerage service operates in an area of service gap with sufficient numbers of Aboriginal and Torres Strait Islander people likely to benefit.*

Assessment Criterion Two: *Proposal will increase access to primary health care services and the coordination of follow-up care by a range of primary health care providers.*

Assessment Criterion Three*: Proposal has support from local Aboriginal and Torres Strait Islander people and health service providers, and the health service providers have the capacity to participate in the proposed brokerage service.*

Assessment Criterion Four*: Proposal demonstrates value for money.*

Part three includes an Agreement and a Declaration. The Agreement seeks confirmation from the applicant to: release some information about their involvement in the project (name of organisation and amount of funding); produce proof of insurance cover if required; and abide by the terms of the Funding Agreement if successful. At the Declaration the applicant indicates: the total amount of funding requested; that they are legally empowered to enter into a commitment with the Department; and the Application is complete and correct.

8. How will the Applications be assessed?

A selection panel will be established by the Department of Health and Ageing to assess Applications against the assessment criteria and decide on the successful and unsuccessful applicants. The panel will consist of officers from the Department of Health and Ageing and an Indigenous representative (or person with other relevant expertise) who will provide independent advice to the panel. Applications will need to meet all of the four assessment criteria to be considered.

9. Funding Agreement

The successful applicants will be required to sign an OATSIH Funding Agreement with the Australian Government, represented by the Department of Health and

Ageing, before receiving their funding. A number of payments will be made throughout the establishment and implementation phase of the brokerage service. These will generally be based on the provision of deliverables (such as progress reports) to the Department.
A Schedule will be developed with the successful organisation and will form an attachment to the OATSIH Funding Agreement.
As determined in the OATSIH Funding Agreement (Clause 4A) all parties delivering brokerage services on behalf of the brokerage service need to be specified in Item A of the Schedule. Written approval is required by the Australian Government where a party is not specified in Item A of the Schedule.
NOTE: The OATSIH Funding Agreement to deliver brokerage services is available to be downloaded with this information package.

10. Insurance

The Australian Government requirements for insurance are specified in Clause 17- Insurance of the OATSIH Funding Agreement.

11. Taxation and payment methods

You will be required to provide formal information and evidence concerning the organisation's financial situation including insurance and taxation obligations if successful in the Application for Funding process.

12. How to apply

Applicants will need to register at the Grants and Tenders link of **www.health.gov.au** to download the relevant Application documents.
Addendums (responses to questions that fall outside these guidelines) will be emailed to all registered applicants, so please ensure your email address and contact details are correct.
Before submitting the Application, applicants should ensure all necessary information has been provided by completing the Checklist at the end of the Application.
If you have any queries, you can contact the Department of Health and Ageing by emailing brokerage@health.gov.au.
You are encouraged to read the Questions and Answers at the end of these Guidelines before you fill in the Application.

SECTION B: COMPLETING YOUR APPLICATION

A Checklist is provided at the end of the Indigenous Community Health Brokerages Services Application document for your convenience.

Your Application must be completed and signed, as appropriate, at the Declaration (see page 10 of the Application).

Your Application must be typed, single-spaced and in English.

Organisations submitting a Joint Application should include a Letter of Support from each additional organisation involved in the project (eg partners who will work with the lead organisation to deliver brokerage services) which includes:

i) an overview of how the organisation will work with the lead organisation and any other organisation/s to support the successful implementation and ongoing service delivery of the brokerage service;

ii) an outline of the relevant experience and/or expertise the organisation will bring to the brokerage team;

iii) the roles/responsibilities the organisation will undertake, and the resources it will contribute (if any); and

iv) details of a nominated management level contact officer.

All applicants should include Letters of Support from health service providers who have indicated that they will participate in the brokerage service.

Each Letter of Support must be signed by an appropriately authorised person capable of committing that organisation.

If you have any questions regarding your Application please email **brokerage@health.gov.au.** Please keep a copy of the completed Application for your records.

LATE, INCOMPLETE, FAXED or EMAILED Applications will not be accepted

The following points refer to specific components of the Application which must be completed with reference to these points.

Part One – Proposed Organisation's details

1.5 Brief Description of your current organisation's main functions and activities

Include for instance, the aims of you organisation, core business, number of employees or volunteers (if applicable); your internet website address (if applicable). Also briefly describe any primary health care services you currently provide.

1.6 Joint Applications

Please note that the Australian Government will only sign an agreement for this funding with the organisation nominated at Question 1.1. This 'lead organisation' receives the funding, and assumes legal responsibility for delivering the services in Australia as outlined in the Schedule of the Agreement. This organisation must therefore be a legal entity able to enter into an Agreement with the Commonwealth, represented through the Department.

Letters of Support must be provided from each additional partner organisation, and attached to this Application, outlining how it will work with the lead organisation and any other organisation/s to support the successful completion of the project.

Part Two – Application for Funding

Please note the Application for Funding consists of 4 components:

- Assessment Criteria;
- Implementation Plan;
- Reporting Requirements; and
- Risk Assessment

1. Assessment Criteria

All criteria will need to be addressed. The assessment criteria to be used by the selection panel when assessing Applications are:

Assessment Criterion One*: Proposed location of the brokerage service operates in an area of service gap with sufficient numbers of Aboriginal and Torres Strait Islander people likely to benefit.*

The applicant will need to demonstrate that the proposed brokerage service will: be located in an urban centre of Australia; does not duplicate or compete with existing Indigenous specific health services (i.e. located in an area of current

Indigenous specific service gap); and be able to service a minimum population of 2,500 Aboriginal and Torres Strait Islander people.

Assessment Criterion Two: *Proposal will increase access to primary health care services and the coordination of follow-up care by a range of primary health care providers.*

The applicant will need to demonstrate that the proposed brokerage service has the potential to: meet the identified health needs of the region; address the barriers faced by local Aboriginal and Torres Strait Islander people in accessing appropriate mainstream health services (for example by providing culturally secure health services); result in an increased use of Medicare Benefit Schedule items including increased health checks and chronic disease management; and improve the follow-up and coordination of care to treat and manage chronic disease. The applicant will also need to demonstrate that the brokerage service will be accountable to the local Aboriginal and Torres Strait Islander community and services will be delivered using good governance and organisational skills.

Assessment Criterion Three*: Proposal has support from local Aboriginal and Torres Strait Islander people and health service providers, and the health service providers have the capacity to participate in the proposed brokerage service.*

The applicant will need to demonstrate that: they have the capacity to effectively engage and network with local Aboriginal and Torres Strait Islander people; the local Aboriginal and Torres Strait Islander people support the proposed brokerage service; the proposed Brokerage service would have access to a broad range of mainstream health care providers (including allied health service providers) who are capable of contributing to coordinated care (i.e. at a sufficient level to provide increased access to primary health care services for local Aboriginal and Torres Strait Islander people); and the health care providers are willing to participate in the proposed brokerage service.

Assessment Criterion Four*: Proposal demonstrates value for money.*

The proposed brokerage service needs to demonstrate value for money and lead to an increased use of Medicare Benefit Schedule items (including increased health checks and chronic disease management) and increase the follow-up and coordination of care to treat and manage chronic disease. This will be measured in terms of the value added by the brokerage service in its ability to increase levels of access to a broad range of local mainstream health services by local Aboriginal and Torres Strait Islander people in proportion to the level of funding being proposed by the applicant.

2. Implementation Plan

Applicants will be required to include an implementation plan which lists the specific tasks to be undertaken to implement the brokerage service including priorities, timeframes and who will be responsible. Please ensure that you clearly identify the activities that will be undertaken to establish the brokerage service.

3. Reporting Requirements

The Application for Funding will need to clearly identify the outcomes the brokerage service intends to achieve and how it will know that these have been achieved. This means identifying performance indicators to monitor activity and determine the effect services have had on access by existing and potential Indigenous members.[1]

When developing performance indicators it will be important to ensure that the measures are useful, have a basis of comparison where possible, are clearly defined and based on data that can be collected as part of standard business administrative processes.

Performance indicators developed by brokerage services to meet their particular local needs will be supplemented by mandatory measures developed by the Department that will apply to all brokerage services. These mandatory measures will encompass brokerage service delivery, management, linkages and coordination and community involvement. Mandatory measures will be reported in OATSIH's Service Development and Reporting Framework (SDRF).[2]

In addition, it is important that applicants specify business processes and systems to manage data collection, analysis and storage that ensure privacy and confidentiality of members' information in their Application.

4. Risk Management

Applicants will be required to include a risk assessment for the key activities for the establishment and ongoing operation of the brokerage service in their Application. This will need to include the likelihood of the risks and proposed strategies to address these risks.

[1] See for example Australian Health Minister's Advisory Council, 2006, *Aboriginal and Torres Strait Islander Health Performance Framework Report* 2006, AHMAC, Canberra and *Primary Health Care Collaboratives Program*, Department of Health and Ageing, Canberra, and *Healthy for Life Program*, Department of Health and Ageing, Canberra.

[2] SDRF is the national non-financial reporting framework which requires annual Action Plans be submitted to OATSIH and reported against every six months (in February and August) assisting organisations to plan and review their activities. The SDRF, through Action Plans and reports, provides a mechanism to evaluate and adapt delivery if required and will need to fit in with the direction set out in the Application for Funding.

Part Three - Agreement and Declaration

The Agreement form requires applicants to indicate their agreement to the three statements.

The Declaration form requires applicants to provide the total amount of funding being applied for (GST exclusive) and sign that the information provided in the Application is complete and correct.

SECTION C: QUESTIONS AND ANSWERS

These are some questions you may have about the Indigenous Community Health Brokerage Services Initiative and the Application process. You can receive further assistance by emailing questions to brokerage@health.gov.au

Q1. Can my organisation apply to establish more than one brokerage service under this funding process?

A1. No. Given the limited number of organisations to be funded under the Indigenous Community Health Brokerage Services Initiative and the localised nature of the proposed service delivery, each organisation may apply for only one grant under this funding process.

Q2. Can a single brokerage service cover two regions?

A2. Yes, provided that the two regions are governed by a single brokerage service. The way in which this will be managed should be clearly set out in the Application.

Q3. Can an Application be submitted jointly by a number of organisations?

A3. Yes. If the brokerage service involves more than one organisation, a joint Application can be submitted. The Australian Government represented by the Department of Health and Ageing will sign the final Funding Agreement with the new incorporated body to deliver brokerage services.

Q4. Will the successful applicant receive funds before the new body is created?

A4. The successful organisation will receive the money in an ‘auspice’ relationship until the new body has been fully incorporated. The auspice will be legally responsible for the brokerage service and the funds. This arrangement will terminate once the organisation becomes incorporated and a new Funding Agreement is in place.

Q5. What role can an Aboriginal Community Controlled Health Organisation (ACCHO) play in the Brokerage service?

A5. An ACCHO can be a lead agency to auspice a brokerage service in this funding process as long as the brokerage service is separately incorporated; operates in an area where a service gap exists (ie does not duplicate existing Indigenous specific health services); and refers members primarily to local mainstream health services (Applications should detail arrangements to manage any potential conflicts of interest).

Q6. Can I apply for funds to enhance an existing ACCHO?

A6. No. The provision of funds for the Indigenous Community Health Brokerage Services Initiative is designed to provide an access point for the provision of mainstream primary health care services for Indigenous Australians.

Q7. What is a Lead Organisation?

A7**.** The funding available under the Indigenous Community Health Brokerage Services Initiative represents sizeable amounts of money. In order to manage these funds appropriately, organisations that take part will be expected to sign an Agreement with the Australian Government. The lead organisation for each project is the organisation that signs the Agreement, receives the funding, and assumes legal responsibility for delivering the services outlined in the Schedule to the Agreement. Lead organisations must therefore be legal entities (incorporated bodies) able to enter into an OATSIH Funding Agreement.

The other organisations listed on the Application Form do not have to be incorporated.

Q8. How much funding can I get from this component of the Indigenous Community Health Brokerage Services Initiative?

A8. The size of the funding available under this Initiative will vary as it is a competitive funding process.

Q9. Can I be allocated less funding than I asked for?

A9. It is expected that budgets provided in the Application will be realistic. The budget you provide will be considered as part of the assessment process. If you are successful in the Application process, the agreed funding provided by the Department will be based on your budget and you will be expected to provide all deliverables specified in your Application within that budget.

Q10. When will I find out if my Application has been successful?

A10. The selection process may take some time to complete, but it is anticipated that applicants will be notified of the outcome of by late November 2008.

Q11. When will my organisation receive the funds?

A11. If you are successful with your Application you will receive funding for the establishment of the service and ongoing operational costs. These funds will be made available to the relevant organisation following signing of the OATSIH Funding Agreement by both your organisation and the Department of Health and Ageing representing the Australian Government. It is anticipated that this funding will commence in early December 2008.

Payments will be generally based on deliverables (eg progress reports) that will be set out in your Application for Funding and the OATSIH Funding Agreement with the Department.

Q12. Are there GST or income tax issues involved in receiving *Indigenous Community Health Brokerage Services Initiative* funding?

A12. Yes. Clause 27 of the OATSIH Funding Agreement outlines the taxes, duties and government charges that funded organisations will be responsible for. This includes Goods and Services Tax (GST). It is important that you familiarise yourself with the contents of the attached OATSIH Funding Agreement.

Q13. Can assets be purchased with Indigenous Community Health Brokerage Services Initiative funding?

A13. Small office assets (eg mobile phones, laptop computers) may be funded if required to meet the service delivery requirements of the brokerage service. Applications must provide a clear justification for the purchase of such items. Alternative arrangements, such as leasing of the asset, should also be considered and included in the budget.

Q14. What happens if we are not ready to start?

A14. The budget provided in the Application will need to include activities and costs to meet approximately three months of establishment (ie December 2008 - February 2009) and will also need to include activities and costs for the ongoing operation of the brokerage service for the remaining four months of 2008/09, and the 2009/10 financial year.

It is essential that the brokerage service is ready for implementation by March 2009. The Application will need to set out strategies in the risk assessment plan to ensure all timelines and project milestones are met.

Q15. What is meant by implementation?

A15. Implementation is considered to be the point at which the organisation has commenced operations as outlined in your Application and agreed through the OATSIH Funding Agreement. It is expected that brokerage services will be available to people participating in the brokerage service within three months of signing the OATSIH Funding Agreement.

Q16. When is the closing date for Applications?

A16. One original and four copies of the Applications (paper copies and CD ROM) must be received at the Department's tender box by:

2.00pm Australian Eastern Daylight Savings Time on Thursday 30 October 2008.

The address for lodging Applications is:

ITA – 060/0809

Indigenous Community Health Brokerage Services Initiative

Tender Box
Department of Health and Ageing
Ground Floor
Penrhyn House, C Block
Bowes Street, WODEN ACT 2606

Q17. Will late Applications be accepted?

A17. No. In the interests of fairness, late, incomplete, faxed or emailed Applications cannot be accepted.

Q18. Can we submit the electronic version of the Application via email?

A18. No. The electronic version of the Application MUST be submitted on a CD ROM in the same package as the original paper copies of the Application.

Q19. Who can I contact for help if I am having trouble filling out the Application?

A19. You can email brokerage@health.gov.au with any questions you may have about completing your Application. Please note that questions and answers will be circulated to all potential applicants to ensure transparency and fairness in this competitive process.

If you have questions or would like assistance with your Application, please email **WELL BEFORE** the closing date, to allow time to finish and submit your Application by the deadline.

CHECKLIST

To complete an Application for the Indigenous Community Health Brokerage Services Budget Initiative applicants are required to:

 Complete the Proposed Organisation details (part one);

 Complete the Application for Funding (part two) as specified in these guidelines, which details the proposed brokerage service by addressing the assessment criteria, includes an implementation plan, addresses the reporting requirements, and includes a risk assessment plan;

 Complete the Agreements and Declaration form (signed by Lead Agency) (part three).

 Your Application must include the following (in the one package):

1. An **original** Application (fully complete) that includes:

 Proposed Organisation details- letter of support from partners if joint Application (part one);

 Application for Funding (assessment criteria, implementation plan, reporting requirements, and risk assessment) & letters of support from health service providers who agree to participate in the brokerage service – (part two); and

 Agreement and Declaration Form (part three).

2. Four (4) **unbound** (not stapled) **copies** (Word format, single sided) of the entire Application (ie parts one – three) and supporting documents; and

3. An **electronic copy** of the Application, fully complete (ie parts one – three) and supporting documents (as a CD ROM).

 Applications should be in English and single spaced.

 Keep a copy of the completed Application for your records.

LATE, INCOMPLETE, FAXED or EMAILED Applications will not be accepted

If you have any questions regarding your Application please email **brokerage@health.gov.au**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-111

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Payne asked:

What is the average response time from submission of a funding application to notification being delivered to the Aboriginal Medical Service?

Answer:

The response time depends on the criteria for assessing the application, what further information may be required, when it is received and in some cases when funding becomes available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-112

OUTCOME 8: Indigenous Health

Topic: COMMUNITY CONTROLLED HEALTH SERVICES

Written Question on Notice

Senator Payne asked:

a) In the last two years, how many Aboriginal and Torres Strait Islander community controlled health and substance use services have had their funding discontinued or not renewed?
b) How many of these had applied for a continuation of their funding?
c) In each case, why was the funding ceased or not renewed?

Answer:

a) – c)

Six (6) Aboriginal and Torres Strait Islander community controlled health and substance use services have had their funding discontinued or not renewed in the last two years.

Name of Organisation: Weimija Aboriginal Corporation (Broken Hill, NSW)

Funding ceased when the Organisation entered into voluntary insolvency. Funding was transferred to Maari Ma Health Aboriginal Corporation (Maari Ma), Broken Hill to ensure continuity of service delivery.

The organisation did not apply for a continuation of funding.

Name of Organisation: Nyampa Aboriginal Housing Company (Menindee, NSW)

The Organisation was unable to meet funding agreement requirements. Successful negotiation resulted in transfer of funds to Maari Ma.

The organisation did not apply for a continuation of funding.

Name of Organisation: Armidale and District Services Incorporated, (Armidale, NSW)

Funding was offered by the Department to the organisation however, they declined to accept the funding because they did not agree with the Commonwealth's conditions of funding.

The organisation did not apply for a continuation of funding.

Name of Organisation: Karu:Aboriginal Child Care Agency, (Darwin, NT)

The Department undertook an open funding round for the provision of Link Up services in the Top End of the Northern Territory in 2007. Karu had been the provider prior to the tender but were unsuccessful in their application.

The organisation did apply for a continuation of funding but were not the successful applicant of the open tender process.

Name of Organisation: Meeanjin Community Referral Centre (Brisbane, QLD)

Funding ceased when the organisation closed down and ceased service provision. Funding was transferred to the Aboriginal and Islander Community Health Service, Brisbane.

Name of Organisation: Goldfields/Esperance Federation of Aboriginal Health (Kalgoorlie, WA)

The Department undertook a National tender for the delivery of Emotional and Social Well Being service delivery. The Organisation did not lodge its application prior to the closing date for tenders.

The organisation did not apply for a continuation of funding by the closing date for tenders.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-153

OUTCOME 8: Indigenous Health

Topic: NARROGIN AND SOUTH WEST ABORIGINAL MEDICAL SERVICES

Hansard Page: CA 29

Senator Siewert asked:

a) The Injury Control Council of WA has received $100,000, GST exclusive, under the National Suicide Prevention Strategy to provide educational programs and services to families. Where is that position based?

b) Does the suicide prevention project focus on Narrogin or on the whole of the South West?

c) You mentioned that the funding for the family support worker was available through to June. Are these support workers going to be there after June? Do they know their future?

Answer:

a) The funding amount was not provided for a specified position. Of the $100,000 an amount of $17,500 (GST exclusive) is provided to increase the hours of the existing project officer based in the South West from 0.6FTE (Full-time equivalent) to 0.8FTE to deliver activities specifically for the Narrogin region. The remainder of the funding is for service providers costs to deliver workshops and seminars in Narrogin.

b) The additional $100,000 (GST exclusive) is for additional activities focussed on Narrogin.

c) The Department will continue to fund South West Aboriginal Medical Service (SWAMS) for $135,000 (GST exclusive) in 2009-10 to provide a Social Worker and an Aboriginal Family Support Worker to deliver services in Narrogin. The Department has also contributed $36,000 (GST exclusive) towards a vehicle for SWAMS for its Narrogin operations.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-155

OUTCOME 8: Indigenous Health

Topic: HALLS CREEK SERVICE STATION AND OPAL FUEL

Hansard Page: CA 47

Senator Siewert asked:

Regarding the service station in Halls Creek that was closed for renovation. Has the service station in Halls Creek re-opened and what is the situation there?

Answer:

The Roadhouse in Halls Creek has confirmed they are not currently supplying fuel. On 15 May 2009, the proprietor of this roadhouse informed a representative of the Department of Health and Ageing that Opal fuel will be supplied when fuel operations recommence.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-156

OUTCOME 8: Indigenous Health

Topic: ALICE SPRINGS OPAL FUEL

Hansard Page: CA 48

Senator Siewert asked:

A wholesaler in Alice Springs is still stocking sniffable fuel. I am just wondering if you are doing any work on this. You highlighted the fact that they are wholesalers, not retailers, which means members of the public cannot buy it, but obviously that means there is a supply in Alice Springs. I am interested to know:

a) Are you talking to them about it?

b) Where is it going?

Answer:

a) The Central Australian Petrol Sniffing Strategy Unit (CAPSSU) has spoken to the business about their stock of regular unleaded petrol. The Australian Government will continue to raise this issue with the wholesaler periodically.

b) It is understood from discussions with the wholesaler that regular unleaded fuel is stored for distribution to other sites (outside Alice Springs). The wholesaler has not provided the names of specific sites or quantities sold.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-235

OUTCOME 8: Indigenous Health

Topic: INDIGENOUS HEALTH

Written Question on Notice

Senator Adams asked:

Do the new estimates released by the ABS about the gap in life expectancy between Indigenous and non-Indigenous people mean there has been a significant improvement in Indigenous health, a reduction in non-Indigenous health or is it a statistical blip?

Answer:

The new Indigenous and non-Indigenous life expectancy estimates released by the ABS do not reflect a change in the gap between Indigenous and non-Indigenous health. Rather, they reflect a change in the statistical methods employed by the ABS to estimate life expectancy in the Indigenous Australian population.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-249

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE PROGRAM

Written Question on Notice

Senator Adams asked:

A question had been asked relating to Healthy for Life Program in February 09 regarding the wide cultural and linguistic variations among Aboriginal and Torres Strait Islanders and that it is neither possible nor appropriate to use a single communication tool. However as part of the ITCI there will be a 'culturally appropriate intervention program' can you please explain how this is different?

Answer:

The Indigenous Tobacco Control Initiative (ITCI) will undertake work to address Indigenous tobacco consumption by trialling community interventions such as smoking prevention and smoking cessation programs, and targeted communication approaches. Activities will include the development and distribution of locally relevant resources that are culturally appropriate. There is no difference between this approach and the approach taken under the *Healthy for Life* program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-250

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Adams asked:

The 10th Rural Conference in Cairns recommended that there be new targeted funding for Aboriginal medical services to run oral and dental health programs. Is this being considered?

Answer:

According to the Service Activity Reporting (SAR) data collected by OATSIH from 145 Aboriginal and Torres Strait Islander primary health care services that received Australian Government funding during 2006–07, 59% of services provided dental care and 30% of services provided dental radiology.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-251

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE

Written Question on Notice

Senator Adams asked:

Regarding the Healthy for Life and New Directions Mothers and Babies Services Conference, will there be a report available regarding discussions that took place?

Answer:

The Department of Health and Ageing has postponed the *Healthy for Life and New Directions Mothers and Babies Services Conference* that was scheduled for 10-12 June 2009.

The Department decided to postpone the conference on advice from the Chief Medical Office, Professor Jim Bishop, following concerns raised by Associate Professor Paul Torzillo about the risk of transmission of the H1N1 virus to the health workers attending the conference and in turn their local communities.

A revised date for the conference has not been set.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-252

OUTCOME 8: Indigenous Health

Topic: HEALTHY FOR LIFE

Written Question on Notice

Senator Adams asked:

a) What sort of reporting strategies do you have in place regarding the implementation for the Healthy for Life Program?

b) If there is going to be both short and long term reporting plans, when should we expect these short term plans?

Answer:

a) Healthy for Life funded services report aggregated Healthy for Life Essential Indicator data using the Office for Aboriginal and Torres Strait Islander Health Support, Collection, Analysis and Reporting (OSCAR) web-based tool during two reporting periods each year.

The Healthy for Life maternal and child health Essential Indicator data are reported annually (for the period 1 July-30 June) in August each year with the three chronic disease Essential Indicators reported twice a year in February (for the period 1 July-31 December) and August (for the period 1 July-30 June).

The data is used to generate individual service and national level reports. These reports inform the service's continuous quality improvement (CQI) processes by collating the information provided in a standard format, highlighting key points and providing commentary on data quality and progress against the indicators.

Healthy for Life funded organisations are required to develop and implement an approved annual Healthy for Life Action Plan based on the findings and analysis of annual clinical audits, service and process mapping, systems assessment and data from their individual service reports. Reporting is in accordance with agreed timeframes (usually 6 monthly).

b) The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is moving ahead with its reform of reporting requirements, and in May 2009 undertook further consultation with key stakeholders based on the directions proposed in the Consultation Paper: Review of Reporting Requirement for OATSIH Funded Organisations (available on the Department of Health and Ageing's website). The revised reporting requirements for OATSIH service providers will include a streamlined set of questions, with the phased implementation of a web-based reporting tool and improved reporting back to service providers. Some simplifications will be made for reporting in 2009-10 with web-based reporting rolled out over the subsequent financial years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-253

OUTCOME 8: Indigenous Health

Topic: NARROGIN

Written Question on Notice

Senator Adams asked:

It was stated from the February 09 Estimates that an Indigenous family support worker had commenced employment on 3 February 2009. Has there been any feedback as to the community response to the support worker?

Answer:

Feedback received from community contact has been positive and constructive. The intervention has been well received.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-254

OUTCOME 8: Indigenous Health

Topic: NARROGIN

Written Question on Notice

Senator Adams asked:

The visits by Aboriginal Health workers and health promotion officer to Narrogin, can you please provide feedback as to the success of this visit?

Answer:

The visits by Aboriginal Health Workers and Health Promotion Officers to Narrogin have received positive feedback from the community.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-255

OUTCOME 8: Indigenous Health

Topic: NARROGIN

Written Question on Notice

Senator Adams asked:

a) In relation to the 12 Indigenous clients with 39 occasions of service, can you provide a breakdown as to the type of service provided?

b) Can you also tell me, 12 clients out of a possible how many?

Answer:

a) The clients were attended to by a Social Worker and a Family Support Worker.

b) The total Indigenous population of Narrogin is 360.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-256

OUTCOME 8: Indigenous Health

Topic: NARROGIN

Hansard Page: Written Question on Notice

Senator Adams asked:

a) Regarding the pilot project with the Aboriginal Health Council of WA to develop a national cultural safety training program, when exactly will this begin?

b) What is the fee breakdown for this service?

Answer:

a) The development of the national cultural safety training program commenced in 2005, training materials were finalised and training commenced in 2007.

b) There are five modules and each module costs $300 per person.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-306

OUTCOME 8: Indigenous Health

Topic: RHEUMATIC HEART DISEASE

Written Question on Notice

Senator Boyce asked:

a) Is the Department aware of the Rheumatic Heart Disease (RHD) checks being performed by Indigenous Volunteers and the Menzies School of Health Research?

b) Does the department offer funding to these organisations to conduct these checks?

c) If the Department is providing funding, how long is the program funded for?

d) How many people will be checked during the program?

e) What support services are available for the ongoing treatment of those with RHD?

Answer:

a) Yes.

b) Yes.

c) The project is funded for 3 years and the screening will occur over approximately two years.

d) The project aims to screen 5,000 school aged children (i.e. children aged 5-14 years): this includes 4,000 children in remote Indigenous communities in the Top End, Central Australia, Kimberly, Far North Queensland and the Torres Strait, and 1,000 Indigenous and non Indigenous children in Darwin, Cairns and Broome.

e) Where children are found to have RHD, the local health service manager is notified and, if available, the child's general practitioner (GP), the usual community paediatrician, the local paediatric cardiologist and the regional RHD programme. The regional study coordinator ensures the family and child are appropriately informed and referred for follow up according to the National Heart Foundation guidelines

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-105

OUTCOME 8: Indigenous Health

Topic: OATSIH FUNDING

Written Question on Notice

Senator Payne asked:

a) How much funding has been allocated to OATSIH in this financial year, and the last financial year?
b) How much of this funding, for both years, is allocated to Aboriginal and Torres Strait Islander community controlled health and substance use services?

Answer:

a) In 2007-08, $471.963 million was expensed under Program 8.1 Aboriginal and Torres Strait Islander Health (refer to page 140 of the 2007-08 Annual Report).

   In 2008-09, $505.197 million is estimated to be expensed under Program 8.1 Aboriginal and Torres Strait Islander Health (refer to page 239 of the 2009-10 Portfolio Budget Statements).

b) Of the 2007-08 Expense, $290.722 million (GST exclusive) was allocated to Aboriginal and Torres Strait Islander community controlled health and substance use services.

   Also, $11.668 (GST exclusive) million was allocated to Aboriginal and Torres Strait Islander community controlled peak bodies.

   Of the 2008-09 Expense, $328.625 million (GST exclusive) was allocated to Aboriginal and Torres Strait Islander community controlled health and substance use services.

   Also, $18.742 million (GST exclusive) was allocated to Aboriginal and Torres Strait Islander community controlled peak bodies.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-106

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICE

Written Question on Notice

Senator Payne asked:

a) How many Aboriginal and Torres Strait Islander community controlled health and substance use services currently receive funding from OATSIH?
b) Can the department provide a list of each organisation, and a breakdown by state and territory?

Answer:

a) The number of community controlled health and substance use services that received funding from OATSIH in 2008-09 was 172.

b) The listing of organisations by state and territory is at Attachment A.

Attachment A

Listing of Community Controlled Organisations (Health and Substance Use services)

State	Organisation Name
ACT	Winnunga Nimmityjah Aboriginal Health Clinic/Health Service (ACT) Incorporated
NSW	Aboriginal Medical Service Co-operative Limited
	Aboriginal Medical Service Western Sydney Co-operative Ltd
	Awabakal Newcastle Aboriginal Co-operative Limited
	Benelong's Haven Limited
	Biripi Aboriginal Corporation Medical Centre
	Bourke Aboriginal Health Service
	Bulgarr Ngaru Medical Aboriginal Corporation
	Condobolin Aboriginal Health Service Incorporated
	Coomealla Health Aboriginal Corporation
	Dharah Gibinj Aboriginal Medical Service Aboriginal Corporation
	Durri Aboriginal Corporation Medical Services
	Galambila Aboriginal Health Service Incorporated
	Griffith Aboriginal Community Medical Service Incorporated
	Illawarra Aboriginal Medical Service Aboriginal Corporation
	Katungul Aboriginal Corporation Community & Medical Services
	Maari Ma Health Aboriginal Corporation
	Marrin Weejali Aboriginal Corporation
	Namatjira Haven Ltd
	Ngaimpe Aboriginal Corporation (The Glen)
	Orana Haven Aboriginal Corporation
	Orange Aboriginal Health Service Incorporated
	Pius X Aboriginal Corporation
	Rekindling The Spirit Limited
	Riverina Medical and Dental Aboriginal Corporation
	Roy Thorne Substance Misuse Rehabilitation Centre Incorporated
	South Coast Medical Service Aboriginal Corporation
	South Coast Womens Health & Welfare Aboriginal Corporation
	Tharawal Aboriginal Corporation
	The Oolong Aboriginal Corporation
	Thubbo Aboriginal Medical Co-operative Ltd
	Walgett Aboriginal Medical Services Co-operative Limited
	Walhallow Aboriginal Corporation
	Weigelli Centre Aboriginal Corporation
	Wellington Aboriginal Corporation Health Service
	Yerin Aboriginal Health Services Incorporated
NT	Aboriginal and Islander Alcohol Awareness and Family Recovery Incorporated
	Ampilatwatja Health Centre Aboriginal Corporation
	Anyinginyi Health Aboriginal Corporation
	Barkly Region Alcohol & Drug Abuse Advisory Group Incorporated
	Central Australian Aboriginal Alcohol Programs Unit
	Central Australian Aboriginal Congress Incorporated
	Central Australian Stolen Generation & Families Aboriginal Corporation
	Council for Aboriginal Alcohol Program Services Incorporated
	Cunnamulla Aboriginal Corporation for Health
	Danila Dilba Health Service
	Demed Association Incorporated Homeland Resource Centre
	Ilpurla Aboriginal Corporation
	Kalano Community Association Incorporated
	Katherine West Health Board Aboriginal Corporation
	Laynhapuy Homelands Association Incorporated
	Malabam Health Board Aboriginal Corporation
	Marthakal Homeland and Resource Centre Association
	Miwatj Health Aboriginal Corporation
	Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council Aboriginal Corporation
	Ngkarte Mikwekenhe Community Incorporated
	NT Stolen Generations Aboriginal Corporation
	Pintupi Homelands Health Service
	Ramingining Homelands Resource Centre Aboriginal Corporation
	Sunrise Health Service Aboriginal Corporation
	Urapuntja Health Service Aboriginal Corporation
	Warlpiri Youth Development Aboriginal Corporation
	Western Desert Nganampa Walytja Palyantjaku Tjutaku
	Wurli Wurlinjang Aboriginal Corporation

State	Organisation Name
QLD	Aboriginal & Torres Strait Islander Community Health Service Brisbane Limited
	Aboriginal and Torres Strait Islanders Community Health Service (Mackay) Limited
	Aborigines and Islanders Alcohol Relief Service Limited
	Australian First Nations Academy for Cultural Family Therapy and Counselling Ltd.
	Barambah Regional Medical Service (Aboriginal Corporation)
	Bidgerdii Aboriginal and Torres Strait Islanders Corporation Community Health Service
	Charleville and Western Areas Aboriginal and Torres Strait Islanders Corporation
	Congress Community Development and Education Unit Limited
	Darling Downs Shared Care Incorporated (T/A Carbal Medical Centre)
	Djarragun College Limited
	Ferdy's Haven Alcohol Rehabilitation Aboriginal Corporation
	Gallang Place Aboriginal and Torres Strait Islander Corporation
	Gindaja Treatment and Healing Indigenous Corporation
	Goolburri Health Advancement Aboriginal Corporation
	Goondir Aboriginal and Torres Strait Islanders Corporation for Health Services
	Goori House Addiction Treatment Centre
	Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation
	Gurriny Yealamucka (Good Healing) Health Services Aboriginal Corporation
	Kalwun Health Service
	Kambu Medical Centre Ipswich Incorporated
	KASH Aboriginal Corporation
	Krurungal - Aboriginal and Torres Strait Islander Corporation for Welfare Resource and Housing
	Link-Up (Queensland) Aboriginal Corporation
	Mamu Health Service Limited
	Milbi Incorporated
	Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation
	Mount Isa Aboriginal Community Controlled Health Services Ltd
	Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation
	Mulungu Aboriginal Corporation Medical Centre
	Nhulundu Wooribah Indigenous Health Organisation Incorporated
	Northern Peninsula Area Women's Shelter Aboriginal and Torres Strait Islander Corporation
	Pormpur Paanth Aboriginal Corporation
	Queensland Aboriginal & Torres Strait Islanders Corporation for Alcohol & Drug Dependence Services
	Townsville Aboriginal and Islander Health Service Limited
	Wuchopperen Health Service Limited
	Wunjuada Aboriginal Corporation for Alcoholism and Drug Dependence Service
	Yaamba Aboriginal and Torres Strait Islander Corporation for Men
	Yulu-Burri-Ba Aboriginal Corporation for Community Health
SA	Aboriginal Drug & Alcohol Council of SA Incorporated
	Aboriginal Sobriety Group Incorporated
	Kalparrin Community Incorporated
	Nganampa Health Council Incorporated
	Nunkuwarrin Yunti Incorporated
	Oak Valley (Maralinga) Incorporated
	Pangula Mannamurna Incorporated
	Pitjantjatjara Yankunytjatjara Media Incorporated
	Port Lincoln Aboriginal Health Service Incorporated
	Tullawon Health Service Incorporated
	Umoona Tjutagku Health Service Incorporated.
TAS	Cape Barren Island Aboriginal Association Inc.
	Flinders Island Aboriginal Association Incorporated
	Mersey Leven Aboriginal Corporation
	South East Tasmanian Aboriginal Corporation
	Tasmanian Aboriginal Centre Incorporated
	Tasmanian Aboriginal Child Care Association
	Women's Karadi Aboriginal Corporation

State	Organisation Name
VIC	Albury Wodonga Aboriginal Health Service Incorporated
	Ballarat and District Aboriginal Co-operative
	Bendigo & District Aboriginal Co-Operative
	Cummeragunja Housing and Development Aboriginal Corporation
	Dandenong and District Aborigines Co-operative Limited - Bunurong Health Service
	Gippsland and East Gippsland Aboriginal Co-operative Limited
	Goolum Goolum Aboriginal Co-operative
	Gunditjmara Aboriginal Co-operative
	Kirrae Health Service Incorporated
	Lake Tyers Health & Children Services Association Incorporated
	Mildura Aboriginal Corporation Inc - Mildura
	Moogji Aboriginal Council East Gippsland Incorporated
	Mungabareena Aboriginal Corporation
	Murray Valley Aboriginal Co-operative - Robinvale
	Ngwala Willumbong Co-operative Limited
	Njernda Aboriginal Corporation
	Ramahyuck and District Aboriginal Corporation
	Rumbalara Aboriginal Co-operative
	Victorian Aboriginal Health Service Co-operative Limited
	Wathaurong Aboriginal Co-operative
	Western Suburbs Indigenous Gathering Place Association Inc.
	Winda Mara Aboriginal Corporation
WA	Aboriginal Alcohol & Drug Service (AADS)
	Bega Garnbirringu Health Service
	Broome Regional Aboriginal Medical Service
	Carnarvon Medical Service Aboriginal Corporation
	Derbarl Yerrigan Health Service Incorporated
	Derby Aboriginal Health Service Council Aboriginal Corporation
	Geraldton Regional Aboriginal Medical Service
	Goldfields/Esperance Federation of Aboriginal Health Incorporated
	Jungarni - Jutiya Alcohol Action Council Aboriginal Corporation
	Jurrugk Aboriginal Health Service Aboriginal Corporation
	Kimberley Aboriginal Medical Services Council Incorporated
	Kimberley Stolen Generation Committee Aboriginal Corporation
	Maamba Aboriginal Corporation
	Mawarnkarra Health Service Aboriginal Corporation
	Milliya Rumurra Aboriginal Corporation
	Ngaanyatjarra Health Service (Aboriginal Corporation)
	Nganggawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation
	Ngnowar-Aerwah Aboriginal Corporation
	Nindilingarri Cultural Health Services
	Nooda Ngulegoo Aboriginal Corporation
	Ord Valley Aboriginal Health Service Aboriginal Corporation
	Palmerston Association Incorporated
	Palyalatju Maparnpa Aboriginal Corporation Health Committee
	Paupiyala Tjarutja Aboriginal Corporation
	Puntukurnu Aboriginal Medical Service Aboriginal Corporation
	South West Aboriginal Medical Service Aboriginal Corporation
	Western Australian Network of Alcohol and Other Drug Agencies (WANADA)
	Wirraka Maya Health Services Aboriginal Corporation
	Yorgum Aboriginal Corporation
	Yura Yungi Medical Service Aboriginal Corporation

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-107

OUTCOME 8: Indigenous Health

Topic: ABORIGINAL MEDICAL SERVICES

Written Question on Notice

Senator Payne asked:

a) How many projects put forward for funding by Aboriginal Medical Services are currently waiting for approval?

b) Can the department provide details about when each of these project funding requests was submitted?

Answer:

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) invites applications for funding and also receives ad hoc requests for funding from organisations.

When OATSIH invites applications for funding, a systematic process is followed according to the specific criteria applicable to that funding such as for Healthy for Life and Urban Brokerage in 2008-09.

Unsolicited requests for funding are given careful consideration based on merit, in accordance with government priorities and availability of funds. Organisations are advised of the outcome at completion of assessment.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-108

OUTCOME 8: Indigenous Health

Topic: OATSIH FUNDING POLICY

Written Question on Notice

Senator Payne asked:

a) Can the department provide OATSIH's funding policy for Aboriginal and Torres Strait Islander community controlled health and substance use services?
b) If it does not have one, why not?

Answer:

a) As at 30 June 2009, 68% of the primary health and substance use service delivery organisations funded by Office for Aboriginal and Torres Strait Islander Health (OATSIH) are Aboriginal Community Controlled Health Organisations (ACCHOs). OATSIH has supported the expanded funding of ACCHOs and substance use services for many years, and organisations generally have their ongoing service funding rolled over from year to year, as documented in the Service Development and Reporting Framework process. That process was also created for consideration of one-off development projects, service expansion and capital works, as and when funds have been available.

   ACCHOs are also able to apply for new funding made available through various Budget measures according to funding guidelines that conform both to the purpose for which the funds are appropriated and to the Australian Government's financial management and accountability framework. In future, any funding guidelines will also need to conform to the new Commonwealth Grant Guidelines that came into effect on 1 July 2009.

b) Not applicable, see answer to a) above.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-307

OUTCOME 8: Indigenous Health

Topic: CHILD HEALTH CHECKS

Written Question on Notice

Senator Boyce asked:

a) Can the Department provide the most recent figures regarding the number of child health checks that have been carried out in Indigenous communities?
b) What proportion of communities have been visited to conduct these health checks and how has that number increased compared to the end of the last year?
c) Are there changes in trends regarding the presentations of illnesses?

Answer:

a) As of 31 May 2009, an estimated total of 14,153 valid Child Health Checks have been performed through the Northern Territory Emergency Response and Medicare Benefits Scheme Item 708 since 1 July 2007.

b) Child Health Checks were offered in all communities by September 2008 and continue to be available through routine health care arrangements.

c) No. The prevalence of health conditions identified as at 20 May 2009 are similar to those reported in the May and December 2008 *Northern Territory Emergency Response Child Health Check Initiative Progress Reports.*

Private Health Insurance Administration Council

In the course of my evidence this afternoon [2 June 2009], Senator Cormann requested some statistics on comparative industry margins comparing the year to Mar 2009 with the year to Mar 2008.
The numbers are:
Year to Mar 08: 5.79%
Year to Mar 09: 2.13%

Shaun Gath
CEO, Private Health Insurance Administration Council

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-199

OUTCOME 9: Private Health Insurance

Topic: PUBLIC HOSPITALS

Written Question on Notice

Senator Adams asked:

Has any modelling been done on the impact on public hospitals as they will soon bear the increased pressure of growing waiting lists as patients move from the private clinics to the public health system for treatment?

Answer:

The small number of people who do drop out of private health insurance will not result in a significant additional burden on public hospitals.

Ipsos *Health Care and Insurance Australia 2007* survey data indicate that around 35% of people require hospital treatment in a two year period. As Treasury estimates that around 25,000 people will drop private hospital cover, Australian public hospitals as a whole may see a rise in demand of around 8,000 people in a two year period. The increase in public patients would be around 0.1% of the usual public hospital workload.

At the Council of Australian Governments' meeting in November 2008, the Commonwealth agreed to provide $64.4 billion over five years to the states and territories for state health systems and national health partnerships. This included an additional $22 billion in funding largely for public hospitals, covering the costs of an additional 350,000 emergency department presentations and an additional 370,000 hospital admissions over four years.

Over a two year period when public hospitals could expect to see an extra 8,000 people who have dropped their private health insurance as a result of this measure, the additional Commonwealth funding would provide for an additional 175,000 emergency department presentations and 185,000 public hospital admissions.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-179

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE PARTICIPATION

Hansard Page: CA 42

Senator Cormann asked:

Can you please … confirm for me whether the department and the Government are budgeting for a 2.6 per cent drop in the proportion of Australians with private health insurance over the period of the forward estimates?

Answer:

No. Expenditure on the private health insurance rebate comes from a special appropriation and is demand driven, so is reviewed each year. The current forecasts in the budget and in the contingency reserve are based on rebate expenditure at current membership levels.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-180

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE PARTICIPATION

Hansard Page: CA 43

Senator Cormann asked:

What (do) you expect the number of Australians with private hospital insurance to be, as a proportion of the total population by 2012-13?

Answer:

The Government does not set a target for the proportion of the population with private hospital insurance.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-183

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Hansard Page: CA 78

Senator Cormann asked:

Is … the provision … broken down by routine increases that would happen in the normal course of events every year and by impact of policy changes like the Medicare levy surcharge last year and this one this year—or is the whole provision in the contingency reserve based on what the government would consider routine rate changes moving forward?

Answer:

The growth in the forward estimates for the private health insurance rebates is included in the contingency reserve. This includes assumptions about future premium increases.

The Government agreed that the premium growth component of the private health insurance rebate forward estimates be moved into the contingency reserve on the basis that it should not be published because, if revealed to industry, it could affect the behaviour of the market.

This is consistent with the treatment of other information in Budget estimates that is of a commercial-in-confidence nature.

All Budget measures, whether they incur additional cost or savings, are reflected in the published estimates. Only estimated costs associated with these measures due to rate increases are held in the contingency reserve.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-186

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE

Hansard Page: CA 87

Senator Adams asked:

What is the eligibility of people earning over $75,000 or families and couples earning over $150,000 for public dental facilities?

Answer:

Public dental services are available to Pensioner Concession Card and Health Care Card holders. Generally people earning over $75,000 or families and couples earning over $150,000 are not eligible to access public dental facilities, as their incomes exceed the threshold and as such they would not be entitled to a Pensioner Concession Card or a Health Care Card.

Further information about who is eligible for Pensioner Concession Cards and Health Care Cards is available from Centrelink or through their website at http://www.centrelink.gov.au

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-182

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE REBATES

Hansard Page: CA 67

Senator Cormann asked:

Were (you) asked by the government specifically to provide one option which went to means testing the private health insurance rebate?

Answer:

No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-184

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH INSURANCE REBATES

Hansard Page: CA 79

Senator Cormann asked:

What was your expected saving from reduced private health insurance payments as a result of the three times watered down Medicare levy surcharge measure last year?

Answer:

The rebate savings are estimated to be $740.6 million over four years.

An additional amount is included in the unpublished contingency reserve.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-185

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH

Hansard Page: CA 82

Senator Cormann asked:

In the justification used by health funds to justify their rate change application, in the last round of rate change applications, how many funds raised the impact of the Medicare levy surcharge threshold change on future membership trends as one of the reasons to seek a particular increase in premiums?

Answer:

In the 2009 Premium Round applications, five insurers raised changes to the Medicare Levy Surcharge threshold as one of many reasons for requesting an increase to their premiums.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-181

OUTCOME 9: Private Health

Topic: PRIVATE HEALTH

Hansard Page: CA 44

Senator Cormann asked:

(On what date) were you asked to provide advice (to government of possible changes to the private health insurance rebate)?

Answer:

On 8 December 2008, the Department of Health and Ageing was asked in a Budget context for advice on and suggestions for possible budget measures. Changes to the Private Health Insurance rebate was one of the issues on which advice was provided.

Australian Government

Department of Health and Ageing

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphery

Request for Amendment to Evidence Provided at Budget Estimates Hearing, 4 June 2009: Outcome 10

I am writing to correct a statement that I made at the Budget Estimates Hearing for 2009-10 of the Senate Community Affairs Committee on Thursday 4 June 2009.

Senator Adams asked the following question:

"A number of members of our committee have visited you in Sydney. That was two years ago, so I just wondered if you could give us an overview of where the organisation is going and the achievements that you have had to date. I know it is a big ask."

My response included the following statement:

"...The information that we provide is increasingly sought by the media. We have over 250 citations in the media each year..."

The response was accurate based on the information available at that time. It has been brought to my notice that the statistic provided relates to the number of requests National Breast and Ovarian Cancer Centre receives for interviews and information each year, rather than the number of media citations each year. However, in light of subsequent details now available to me, the response should now be amended as follows (changes are underlined):

"...The information that we provide is increasingly sought by the media. We respond to over 250 media requests for information and interviews each year..."

Yours sincerely

Dr Helen Zorbas
Chief Executive Officer
National Breast and Ovarian Cancer Centre
16 June 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-054

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Lundy asked:

a) What is the role of NEHTA are playing in the ehealth records initiatives?
b) Are NEHTA considering a non-tendered procurement of a system for ehealth records management? If so what is it?
c) Can you guarantee this system is 100% open standards compliant, including data formats, data transport protocols, domain specific terminology and messaging protocols?
d) Does the system have a fully open and documented API (Application Programming Interface) for interoperability with other systems and applications?
e) Can you guarantee that all Australian health and personal data in this system will be stored within Australian jurisdiction?
f) Can you independently assess the security and functionality of this system through access to the source code?

Answer:

All Australian governments are contributing to the development of policy parameters for implementation of a national individual electronic health (IEHR) records system. Any direction taken on the project will be done so with consideration of jurisdictional commitments and priorities.

a) NEHTA's work to date has focused on the key foundations required to support electronic health information exchange across Australia. This includes foundation work on identifiers, authentication and common language, and technical standards. The Council of Australian Government decision to continue funding to 2012 will enable NEHTA to progress the development of critical eHealth standards and infrastructure. This foundation work will support safe and accurate sharing of information between health providers to enable better health care especially for those who, for various reasons, may see a range of health providers.

b) No procurement arrangements are being considered for any national eHealth records management system at this time.

c) Part of NEHTA's role is to develop critical standards, including data formats, data transport protocols, domain specific terminology and messaging protocols. In order to be interoperable, eHealth systems would need to meet these nationally agreed standards.

d) NEHTA is working to develop the technical standards that are required to enable interoperability of eHealth systems, including proposed individual electronic health records.

e) During the planning phase of IEHR implementation, all Australian governments will identify the appropriate storage location of Australian health and personal data.

f) Security and functionality of the IEHR will be managed through a robust privacy and regulatory regime.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-142

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH – NEHTA WORK DUE BY END OF 2009

Hansard Page: CA 70

Senator Boyce asked:

Provide an indication of what work NEHTA is due to complete and to implement this (calendar) year.

Answer:

The work that National E-health Transition Authority (NEHTA) is expected to complete and implement for the remainder of this calendar year includes:

NEHTA outcomes expected to be completed and implemented between 4 June 2009 and 31 December 2009		
Month	**Initiative**	**Outcome**
June	**Clinical terminology** (Standardising key Clinical information)	Australian Medicines Terminology11 (AMT) will contain 99% of Therapeutic Goods Administration (TGA) registrable products including all medicines, dressings, nutritional supplements and diagnostic agents listed under the Pharmaceutical Benefits Scheme.
July	**Discharge summaries** (Electronic exchange of patient reports between hospitals and the primary care sector)	A nationally endorsed electronic discharge summary will be released.
July	**Conformance, compliance and accreditation** (Ensuring that software complies with Australian Standards and NEHTA specifications)	A document describing how a national certification authority for eHealth related software will function will be completed during July.

11 NEHTA's Australian Medicines Terminology (AMT) delivers standard identification of branded and generically equivalent medicines and their components, and standard naming conventions and terminology, to accurately describe medications. The terminology is for use by medication management computer systems, in both primary and secondary healthcare.

November	**Clinical terminology** (Standardising key Clinical information)	First consolidated version of SNOMED CT 12 for Australia will be completed during November. It will incorporate an Australian Language Reference Set, allowing development of Australian preferred terms.
December	**Secure messaging** (World standard secure transfer of health information)	A lead implementation project with the Northern Territory Department of Health and Families will use NEHTA secure messaging specifications to develop a Web Services Messaging Application platform for the transfer of clinical information from participating healthcare providers. This will use selected medical software to eHealthNT's existing Shared Electronic Health Record (SEHR) repository.
December	**Unique healthcare identification (UHI)** (Unique identification of any healthcare provider, organisation or consumer)	The individual healthcare identifier (IHI) and healthcare provider identifiers for individuals and organisations will be designed, developed and delivered as per the contract arrangement with Medicare Australia. (noting that legislation is expected in mid 2010 to allow IHIs to be issued)
December	**Supply chain** (Unique identification of healthcare products such as medicines and medical devices through a national product catalogue)	Fifty leading health product vendors will have their products on NEHTA's National Product Catalogue13.
December	**Referrals** (Exchange of relevant patient healthcare information between healthcare providers)	First release of a nationally endorsed electronic GP referral.
December	**Electronic transfer of prescriptions** (Electronic Medication Management)	Release of specifications to support the trial exchange of electronic prescriptions between GPs and community pharmacies.
December	**E-health engagement and communications** (Stakeholder Engagement)	Launch of the first national e-health web portal.
December	**Clinical terminology** (Standardising key Clinical information)	Release of a live technical demonstration to show the healthcare community the benefits of SNOMED CT and Australian Medicines Terminology (AMT).

12 SNOMED Clinical Terms ® (SNOMED CT), the internationally pre-eminent clinical terminology, has been identified as the preferred national terminology for Australia. SNOMED CT remains freely available for e-health software developers to use in their Australian products, under NEHTA's new licensing arrangements..
13 The catalogue of medicines, medical devices and other products traded in the public and private healthcare sectors contains thousands of healthcare items allocated a unique product identifier to be used, for example, in electronic trading transactions.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-174

OUTCOME 10: Health System Capacity and Quality

Topic: DIABETES - RESEARCH

Hansard Page: CA 75

Senator Barnett asked:

Can you identify them (other forms of research and treatment for people with type1 diabetes) please?

Answer:

It is likely that research directions such as stem cell and other cellular therapies will prove to be more productive in future work towards a cure for diabetes than allotransplantation (the isolation and transplantation of insulin producing pancreatic cells from deceased donors). Allotransplantation is the focus of the clinical program within the Australian Islet Transplantation Program.

Some components of the basic research program within the Australian Islet Transplantation Program are now focusing on these potential therapies, as are some National Health and Medical Research Council (NHMRC) funded research projects.

In 2008, NHMRC allocated $23.6 million on 73 research grants investigating the causes, effects and complications of type 1 diabetes. A summary of each NHMRC research grant for type-1 diabetes is available at the following URL:
http://www.nhmrc.gov.au/grants/dataset/disease/diabetes.php

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-175

OUTCOME 10: Health System Capacity and Quality

Topic: DIABETES - RESEARCH

Hansard Page: CA 76

Senator Barnett asked:

Provide a list of research NHMRC undertakes which supports the diabetes community - type 1 and type 2 over the previous three or four years?

Answer:

A summary of each NHMRC research grant for type-1 and type-2 diabetes is available at the following URL: http://www.nhmrc.gov.au/grants/dataset/disease/diabetes.php

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-053

OUTCOME 10: Health System Capacity and Quality

Topic: INDIVIDUAL ELECTRONIC HEALTH RECORDS

Written Question on Notice

Senator Lundy asked:

How is the individual electronic health records project going?

Answer:

All governments are working collaboratively in advancing eHealth. This work includes the development of the National E-Health Strategy, joint investment in the foundational work of the National E-Health Transition Authority (NEHTA) and the development of, and public consultation in mid 2009 on, an underpinning system of Unique Healthcare Identifiers.

In November 2008, the Council of Australian Governments (COAG) approved $218 million over three years (including Australian Government funding of $108.9 million) in base funding for NEHTA to continue its key eHealth foundations work until June 2012. COAG has asked for a report on the Individual Electronic Health Record in late 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-083

OUTCOME 10: Health System Capacity and Quality

Topic: GENE MUTATIONS

Written Question on Notice

Senator Siewert asked:

Has anyone from Westmead Hospital or NSW Health advised the Department of the difficulties that the Westmead Hospital has had in being able to afford the genetics tests for mutations to the SCN1A human gene (which mutations may lead to Dravet syndrome or otherwise known technically as severe myoclonic epilepsy of infancy (SMEI)? If so, elaborate.

Answer:

No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-084

OUTCOME 10: Health System Capacity and Quality

Topic: GENETIC MUTATIONS TEST

Written Question on Notice

Senator Siewert asked:

a) Is the Department aware that Bionomics gave Genetic Technologies Limited an exclusive licence over the genetic test for mutations to the SCN1A human gene? If so, is the Department able to provide information on the cost of that test?
b) What is the cost to the Australian healthcare system of the genetic test for mutations to the SCN1A human gene?

Answer:

a) This question seeks information about patents and patenting practices, which is a matter for IP Australia. However, the Department is aware that the issue was mentioned in media articles in November 2008. The Department is not aware of the cost of the test.

b) There is no Medicare Benefits Schedule rebate for this genetic test. Funding through the National Healthcare Agreements (NHA) would be a source of resourcing for such specific genetic testing. However, expenditure on genetic testing through the NHAs is not identified separately so specific breakdowns cannot be provided.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 5 June 2009

Question: E09-157

OUTCOME 10: Health System Capacity and Quality

Topic: ASTHMA – ASTHMA FRIENDLY SCHOOLS IN THE NT

Hansard Page: CA 50

Senator Crossin asked:

I noticed that the Asthma Foundation of the Northern Territory is not funded to deliver its Asthma Friendly Schools Program in remote communities. I am just wondering if you know why that might be the case. I think it is perhaps because the Asthma Friendly Schools Program is only for urban areas.

a) Has the delivery of the program to remote schools ever been considered?

b) Has there been a report done about how effective and useful it would be, or about the cost?

c) What ideas are there about getting knowledge about asthma out to those schools?

Answer:

a) The Asthma Foundation of the Northern Territory is funded by the Department of Health and Ageing to deliver the Asthma Friendly Schools (AFS) Program in the Northern Territory. The Foundation actively targets schools in remote areas. Sixteen schools in remote areas of the Northern Territory are currently involved in the AFS Program.

b) Whilst evaluations of the AFS Program are conducted under the current funding arrangements, there has been no specific report on the cost or effectiveness of this program in remote areas of the Northern Territory.

c) As indicated in a) above, sixteen schools in remote areas of the NT are currently involved in the AFS Program. From November 2009 the Australian Government, through Asthma Foundations Australia, will be implementing a revised asthma program for school aged children, the Asthma Child and Adolescent Program. In the NT this program will focus on asthma and linked respiratory conditions, and the development of flexible approaches in the delivery of training and education to meet the needs of Indigenous children and communities in remote areas.

As well as targeting schools through the AFS Program, the Australian Government currently funds two additional initiatives to increase knowledge of asthma in remote communities in the Northern Territory:

Community Support Program (CSP)	Through CSP the NT Asthma Foundation has: • developed several Indigenous specific resources, including indigenous Asthma Action Plans, designed for use in remote regions and sent to contacts, such as Aboriginal Health Workers, in remote regions, the Indigenous specific '*short wind*' suite of resources; • visited thirteen regional centres specifically to deliver asthma education information and training to health professionals, people with asthma and their families; and • maintained an information line accessible to people in remote communities through which they can receive information and advice on managing their asthma.
Asthma Spacer Ordering Scheme (ASOS)	This program provides spacer devices to Indigenous communities through Aboriginal Community Controlled Health Organisations, many of whom operate in remote areas of the Northern Territory. Indigenous specific resources promoting best practice asthma management are provided with each order of spacer devices. A total of 7,406 spacer devices have been delivered to 87 Aboriginal Community Controlled Health Organisations through this scheme.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-173

OUTCOME 10: Health System Capacity and Quality

Topic: DIABETES - LIFT FOR LIFE PROGRAM

Hansard Page: CA74

Senator Barnett asked:

Out of the $31.8 million, how much of that money over that four year period was allocated or dedicated to the Lift for Life Program, if any?

Answer:

The Lift for Life program was allocated a total of $2,017,680 from the commencement of the project in May 2005 to its completion in February 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-080

OUTCOME 10: Health System Capacity and Quality

Topic: MS RESEARCH

Written Question on Notice

Senator Siewert asked:

a) I understand that MS Research Australia has submitted a funding application to fund world-first prevention trial in MS?
b) Is this correct?
c) When will a decision be made?

Answer:

a – c)

The National Health and Medical Research Council (NHMRC) Project Grant Funding scheme is the organisation's main avenue for the support of research projects, such as a specific prevention trial. MS Research Australia is not an applicant in the current funding round, applications for which closed in March 2009. Applications for the support of research in the area of multiple sclerosis have been received from a number of other institutions and are currently being peer reviewed. The announcement of successful applications is scheduled for October 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 4 June 2009

Question: E09-114

OUTCOME 10: Health System Capacity and Quality

Topic: RESEARCH

Hansard Page: CA 25

Senator Boyce asked:

You run the peer review system for Cancer Australia as well as for yourselves.

a) Are there other organisations that you undertake the peer review for?

b) Could you give me a list?

Answer:

a) Yes.

b) In 2009, the outcomes of the Project Grant peer review process will be used by the following external organisations to inform their funding decisions:
   - Department of Health and Ageing;
   - Cancer Australia;
   - Cancer Council;
   - Department of Climate Change;
   - HeartKids Australia; and
   - Heart Foundation.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 009

Question: E09-115

OUTCOME 10: Health System Capacity and Quality

Topic: Reporting

Hansard Page: CA 28-29

Senator Siewert asked:

a) What are the other two reports you mentioned about? (Bernstein and Zerhouni)
b) Could you tell me how much you invested in getting the three reports done? (Bernstein, Zerhouni and Nutbeam)
c) Could you tell us who was on the independent panel that you commissioned to do the Nutbeam report?

Answer:

a) The Bernstein Review and the Zerhouni Review were commissioned to subject the National Health and Medical Research Council's (NHMRC's) research funding processes to international scrutiny.

   The purpose of the "International Review of NHMRC Research Funding Processes" (The Bernstein Review) was to provide advice to the Chief Executive Officer of NHMRC on:
   - NHMRC's research support strategies and peer review processes in relation to international best practice in health and medical research funding organisations;
   - Any aspects of NHMRC processes that may unintentionally disadvantage particular research sectors, groups or philosophies; and
   - Emerging issues, techniques and technologies that may improve efficiencies in current processes, without compromising the quality.

   The purpose of the "International Perspective on the National Health and Medical Research Council's Research Strategies" (The Zerhouni Report) was to focus on the processes that NHMRC uses to select the best research. The review included:
   - Aligning NHMRC funding schemes to support research, people and infrastructure with NHMRC's strategic objectives;
   - Improving NHMRC peer review processes;
   - Improving support mechanisms for biomedical, clinical, health services and public health research; and
   - Improving support for Australian researchers.

b) NHMRC invested a total of $415,814 for the three reviews.
   - $355,814 to undertake the two international reviews of NHMRC's research funding processes (the Bernstein and Zerhouni reviews); and
   - $60,000 to undertake the review of public health research funding in Australia (the Nutbeam review).

c) Membership of the "Review of Public Health Research Funding in Australia" (The Nutbeam Report)
   - Professor Don Nutbeam (Chair), Deputy Vice Chancellor, University of Sydney
   - Associate Professor Toni Ashton, Director, Centre for Health Services Research and Policy, School of Population Health, University of Auckland, New Zealand
   - Associate Professor Emily Banks, National Centre for Epidemiology and Population Health, Australian National University
   - Associate Professor Alan Caas, Director, Renal Division, The George Institute of International Health, University of Sydney
   - Professor Mike Daube, Professor of Health Policy, Curtin University of Technology, President, Public Health Association
   - Associate Professor Stephen Farish, School of Medicine, University of Melbourne
   - Professor Rob Sanson-Fisher, Medical School, University of Newcastle
   - Professor Judith Lumley, Director, Mother and Child Health Research Centre, Division of Health Research, Faculty of Health Sciences, La Trobe university, Melbourne

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2007-2008, 4 June 2009

Question: E09-116

OUTCOME 10: Health System Capacity and Quality

Topic: NALTREXONE TRIALS

Hansard Page: CA 30

Senator Siewart asked:

a) When did you fund the Naltrexone trials?

b) You said there is five projects – what were they, how much were they; and when were they funded?

Answer:

a and b)

Scientific Title	**Chief Investigator A**	**Administering Institution**	**Application Year**	**Total Funding**
A randomised trial of different dose levels of naltrexone as maintenance treatment for opioid dependence.	A/Prof James BELL	University of New South Wales	1999	$198,904
The role of pharmacotherapy in prevention of relapse in alcohol dependence	Prof Paul S HABER	University of Sydney	2001	$422,310
Effect of naltrexone treatment on mental health and other health outcomes: a record linkage study.	Prof Gary K HULSE	University of Western Australia	2002	$111,625
A randomised double blind placebo controlled clinical trial of naltrexone implants for the treatment of heroin addiction	Prof Gary K HULSE	University of Western Australia	2003	$558,675
Assessing naltrexone implant or methadone maintenance treatment on mental and physical health outcomes in heroin users	Prof Gary K HULSE	University of Western Australia	2004	$216,200
			TOTAL	**$1,507,714**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-230

OUTCOME 10: Health System Capacity and Quality

Topic: DON NUTBEAM RESEARCH

Written Question on Notice

Senator Adams asked:

a) Where is the report done on public health research produced for the NHMRC by Don Nutbeam?
b) Why has it not been released to the public?
c) Are there plans for it to be released to the public?

Answer:

a – c)

The Report of the Review of Public Health Research Funding in Australia (The Nutbeam Review) has been completed and is publicly available through the NHMRC website at http://www.nhmrc.gov.au/research/phr/_files/Nutbeam.pdf

NHMRC's response to the Nutbeam Review is also publicly available through the NHMRC website at http://www.nhmrc.gov.au/research/phr/_files/response-to-nutbeam.pdf

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-294

OUTCOME 10: Health System Capacity and Quality

Topic: RESEARCH INTO H1N1

Written Question on Notice

Senator Boyce asked:

The Council has called for urgent research into the H1N1 virus and has put aside $7 million to cover it. Can the council provide an update on progress concerning this research?

Answer:

The National Health and Medical Research Council (NHMRC) proposed to support research over the next 12 months (including a Report to a Workshop in December 2009), to learn more about the biological properties of the H1N1 Influenza 09 virus, and the clinical and public health issues around infection, to inform public policy. This proposal was endorsed at the 27/28 May 2009 meeting of the NHMRC's Research Committee. They recommended that up to $7 million should be allocated from the Medical Research Endowment Account (MREA).

On 29 May 2009 the NHMRC announced the call for research. The full documentation was available on the NHMRC website on 3 June and applications closed at 5pm on 22 June 2009.

The Minister for Health and Ageing announced the successful applicants on 8 July 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-295

OUTCOME 10: Health System Capacity and Quality

Topic: RESEARCH INTO H1N1

Written Question on Notice

Senator Boyce asked:

Applications for the research were due on 22 June 2009. Can the Council tell us how many applications for research are administered, and what criteria do they use when assessing the quality of applicants?

Answer:

110 applications were received by the due date.

The NHMRC appointed a Peer Review Panel comprised of Australian and international (Singapore, New Zealand and the United States of America) experts to advise on the applications. The Panel met in Canberra on Monday 29 June 2009.

The Panel considered the applications based on the announced selection criteria for the call for research:

- Relevance to the aims of the Call for Research
- Scientific quality/merit and/or innovation
- Qualifications and evidence of experience of investigator/s in the use of proposed research techniques
- Overall project design, method and feasibility
- Strength of the proposed research team/consortium
- Ability to commence and complete the proposed research within the given timeframe
- Value for money with particular emphasis on the capability of the researchers being able to report findings in the short term, together with their track record of excellence in the field

The recommendations from the Peer Review Panel were subsequently considered by the NHMRC's Research Committee. They agreed to recommend that the Panel's recommendations be provided to Council. Council in turn agreed that the CEO of the NHMRC advise the Minister for Health and Ageing to make funding of $6.97 million available from the MREA for 41 grants.

The Minister for Health and Ageing announced the successful applicants on 8 July 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 June 2009

Question: E09-339

OUTCOME 10: Health System Capacity and Quality

Topic: GASTRIC BANDING

Hansard Page: CA 113

Senator Adams asked:

What research has been done regarding patients who have been diagnosed with obesity related diseases and their suitability to have this type of surgery.

Answer:

There have been a number of studies into the suitability of gastric band surgery for patients with obesity related diseases.

Relevant research based literature includes:

- *Clinical Practice Guidelines for the Management of Overweight and Obesity in Adults*. Commonwealth of Australia: National Health and Medical Research Council (NHMRC) 2003.
- *Obesity: prevention, identification, assessment and management of overweight and obesity in adults and children*. UK: National Institute for Health and Clinical Excellence (NICE) 2006: 84
- *Health Care Guideline: Prevention and Management of Obesity (Mature Adolescents and Adults). 4th Ed*. USA: Institute for Clinical Systems Improvement (ICSI) 2009.
- *American Association of Clinical Endocrinologists, The Obesity Society, and American Society for Metabolic & Bariatric Surgery medical guidelines for clinical practice for the perioperative nutritional, metabolic, and nonsurgical support of the bariatric surgery patient.* USA: American Association of Clinical Endocrinologists 2008.

Several national and international guidelines state that bariatric surgery (which includes gastric banding) may be a treatment option for adults with Body Mass Index (BMI) greater than 40 or with a BMI greater than 35 if the patient has serious medical comorbidities. Serious medical comorbidities may include type 2 diabetes, hypertension, coronary artery disease, obstructive sleep apnoea, hyperlipidemia or considerably impaired quality of life.

The Australian Government, through the National Health and Medical Research Council (NHMRC) has committed $1.2 million towards research relating to bariatric surgery from 2006-09. Details of the grants are available on NHMRC's website at: http://www.nhmrc.gov.au/grants/dataset/rmis/index.htm

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-273

OUTCOME 10: Health System Capacity and Quality

Topic: BENCHMARKING THE COST OF PALLIATIVE CARE

Hansard Page: CA 58

Senator Siewert asked:

Have you done any benchmarking of the cost of provision of palliative care?

Answer:

No.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-274

OUTCOME 10: Health System Capacity and Quality

Topic: PALLIATIVE CARE INITIATIVES AND FUNDING SOURCES FOR PALLIATIVE CARE

Hansard Page: CA 58-59

Senator Siewert asked:

Can you provide a detailed list of the initiatives and various funding sources for palliative care?

Answer:

Under the Continuation of the National Palliative Care Strategy measure, funding of $14 million, from 2009-10 to 2012-13, is being provided for the Palliative Care Outcomes Collaboration and to update the National Palliative Care Strategy.

The Palliative Care in the Community measure has funding of $57 million provided from 2009-10 to 2012-13. Current initiatives under this program are:

- Palliative Care Clinical Studies Collaborative
- National Health and Medical Research Council Palliative Care Research Program
- Palliative Care Assessment Tool and Referral Guidelines
- Palliative Care Knowledge Network/Caresearch
- Program of Experience in the Palliative Approach
- Palliative Care Curriculum for Undergraduates
- Respecting Patient Choices Project
- Palliative Care Australia Core Funding
- National Standards Assessment Program
- Paediatric Palliative Care Resource (Journeys)
- Rural Palliative Care Project
- People Living at Home

The Local Palliative Care Grants Program has funding of $22 million from 2009-10 to 2012-13.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-052

OUTCOME 10: Health System Capacity and Quality

Topic: eHEALTH

Written Question on Notice

Senator Lundy asked:

How are the eHealth initiatives going?

Answer:

In 2006, the Council of Australian Governments (COAG) agreed to a national approach to developing, implementing and operating systems for individual and healthcare provider identifiers as part of accelerating work on electronic health records to improve the safety of patients and improve efficiency for healthcare providers.

Consultation on proposals for legislation and governance arrangements to support the Healthcare Identifiers Service and national health information privacy arrangements will be conducted in July and August of 2009.

The National E-Health Transition Authority (NEHTA) has contracted Medicare Australia to design, build and test the Healthcare Identifiers Service. The Healthcare Identifiers Service is expected to be operational by mid 2010.

In November 2008, COAG agreed to fund NEHTA until 2011-12 to continue work on a number of projects which include:

- standardised clinical terminologies;
- lead implementation projects in consultation with the pathology sector, that aim to standardise the exchange of information;
- a nationally endorsed electronic discharge summary;
- a trial project with the Northern Territory Department of Health on secure messaging;
- a nationally endorsed electronic General Practice referral; and
- a national eHealth web portal.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-245

OUTCOME 10: Health System Capacity and Quality

Topic: DEPARTMENT OF HEALTH AND AGEING INVOLVEMENT IN ROLL OUT OF BROADBAND

Written Question on Notice

Senator Adams asked:

How is the department involved with plans for the roll-out of broadband and could health be one of the first areas to benefit from faster broadband? If this is to be the case, what will be the situation for towns of less than 1000?

Answer:

The Department is a member of the National Broadband Development Group which is chaired by the Department of Broadband Communication and the Digital Economy (DBCDE). This group identifies and develops opportunities for cross-sectoral and cross jurisdictional cooperation to achieve better outcomes for broadband development. Members of this group receive updates on a range of initiatives managed by DBCDE including the National Broadband Network.

The Department recognises broadband availability, take-up and usage as key factors in the progression of the national eHealth agenda.

The issue of the implications of broadband for towns of less than 1000 will be addressed by the DBCDE in the context of the development and roll-out of the National Broadband Network.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-293

OUTCOME 10: Health System Capacity and Quality

Topic: GUIDELINES ON ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)

Written Question on Notice

Senator Boyce asked:

Can the Council provide details about the Draft Guidelines on ADHD?

Answer:

- The draft *Australian Guidelines on Attention Deficit Hyperactivity Disorder (ADHD)* are being developed by the Royal Australasian College of Physicians (RACP).
- The *National Health and Medical Research Act (1992)* (the Act), authorises the National Health and Medical Research Council (NHMRC) to approve (under section 14A) guidelines prepared by other organisations.
- RACP submitted the draft guidelines to NHMRC in February 2009. The draft Guidelines were considered by the NHMRC Council at its meeting of 10-11 March 2009 and comments were provided to the RACP.
- The RACP have developed a response to Council's comments. Council will consider the RACP's response shortly.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-065

OUTCOME 11: Mental Health

Topic: LONG TERM SERVICES FOR PEOPLE WITH A MENTAL ILLNESS AND THEIR CARERS

Senator Williams asked:

What long term services are being offered for people with mental illness and their carers?

Answer:

There are two long term mental health services administered by the Commonwealth Department of Health and Ageing that support individuals with long term mental illness:

- The *Support for Day to Day Living in the Community* (D2DL) – a Structured Activity Program provides additional places for people with severe and persistent mental illness in structured activities such as art and craft classes, gardening and discussion groups to improve their social participation and independent living skills.

- The *Program of Assistance for Survivors of Torture and Trauma* delivers medium to long term torture and trauma counselling services to humanitarian entrants to Australia who have pre-migration experiences of conflict and human rights abuses which makes them vulnerable to developing mental health problems.The Department of Health and Ageing does not fund long term mental health services for carers of people with mental illness.

The Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) is responsible for the Mental Health Respite Program. This Program provides a range of flexible respite options for carers of people with severe mental illness/psychiatric disability and carers of people with intellectual disability.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-068

OUTCOME 11: Mental Health

Topic: MENTAL HEALTH SERVICES FOR THE AGED POPULATION

Written Question on Notice

Senator Williams asked:

a) Are mental health services for the elderly being expanded?
b) How do you propose to address the growing mental health needs of the ageing population and provide mental health support in aged care facilities and the community?

Answer:

a) The Australian Government is working closely with state and territory governments on approaches to improving outcomes for people with mental illness across the age spectrum from infancy to old age.

   Under the auspices of the Australian Health Ministers' Conference (AHMC), a draft Fourth National Mental Health Plan (the draft Plan) has been developed through a comprehensive process and is currently being finalised for AHMC consideration following final stakeholder consultation.

   The draft Plan recognises that older people have an increased risk of mental health problems through pre-existing illness, and age specific illness such as dementia. It also recognises the importance of care coordination in such situations where general practice, multiple support agencies and clinical specialists are and should be involved. The draft Plan is expected to articulate links between health and other sectors, including aged care, community and disability and housing, and to provide guidance to all governments about service planning, development and implementation of measures.

b) Under the Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule (Better Access) initiative Medicare rebates are available for eligible people with an assessed mental disorder to receive up to 12 individual and up to 12 group allied mental health services per calendar year.

   Under this initiative, General Practitioners (GPs) are able to develop Mental Health Treatment Plans for members of the community who have a diagnosed mental illness and who would benefit from a course of short-term treatment from a psychologist or appropriately trained social worker or occupational therapist. Generally, Commonwealth funded residents of an aged care facility are not able to access allied mental health

services through the Better Access initiative. However, if a resident of an aged care facility is a private in-patient who is being discharged from hospital, the resident may be eligible for a discharge GP Mental Health Treatment Plan, if clinically appropriate.

Residents can obtain certain psychology, social work and occupational therapy services through other avenues provided by the facility. Medicare rebates for some mental health services are also available for eligible residents under the Government's Chronic Disease Management initiative where a GP has contributed to a multidisciplinary care plan prepared by a residential aged care facility.

Under the Government's Dementia Initiative, a Dementia Behaviour Management Advisory Service (DBMAS) has been established in each state and territory. These services provide appropriate clinical interventions to help aged care staff and carers improve their care of people with dementia where the behaviour of the person with dementia impacts on their care.

DBMAS functions include the provision of education and tailored information workshops, clinical supervision and mentoring and modelling of behaviour management techniques.

These activities aim to build staff capacity in aged care services so that they gain increased knowledge and confidence in understanding the needs of people with dementia and in managing care recipients presenting with Behavioural and Psychological Symptoms of Dementia (BPSD).

Under the Aged Care Act 1997 (the Act) approved providers of aged homes are required to meet the Accreditation Standards (the Standards) to ensure that quality of care and quality of life is provided to all residents. Specifically, Standard 2.13 refers to behaviour management and states that the needs of residents with challenging behaviours are managed effectively. A challenge still exists, however, in providing the appropriate care and services for older people with more complex psychogeriatric disorders resulting in behaviours that may place themselves or others at risk. It is recognised that to achieve the best care outcomes for this group of people, collaborative networks across the primary, acute, mental health and aged care service sectors are critical.

A Psychogeriatric Care Expert Reference Group (ERG) has been established to provide advice to the Ministerial Conference on Ageing (MCA) on innovations in treatment and service delivery to residents in aged care homes with more severe psychogeriatric conditions. This includes advice on strategies to foster local collaboration across service sectors.

In 2008 the Government provided $2 million in research funding aimed at improving the care and treatment of people with psychogeriatric conditions in aged care homes. This work is being undertaken collaboratively between the Department of Health and Ageing and the National Health and Medical Research Council (NHMRC).

Under the Australian Government funded Encouraging Best Practice in Residential Aged Care (EBPRAC) program, research institutions and aged care homes are collaborating on a number of projects. Three projects targeting the clinical area of behaviour management of people with dementia and other mental health disorders have recently been funded.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-226

OUTCOME 11: Mental Health

Topic: POOR VISION

Senator Adams asked:

What support will be provided to patients who become depressed due to poor vision?

Answer:

The Commonwealth does not fund initiatives specifically targeting patients who are depressed due to poor vision.

However, the Commonwealth funds a range of programs that provide support for all Australians with mental illnesses including patients with poor vision who are experiencing depression. These programs include:

- *beyondblue: the national depression initiative*, which is a collaborative initiative funded by the Australian, state and territory governments that aims to address issues associated with depression, anxiety and related disorders in Australia. It has a key goal of raising community awareness about depression and reducing stigma associated with the illness. More information, including details on support services, is available by calling the *beyondblue* Info Line on 1300 22 4636 for the cost of a local call or by visiting the website: www.beyondblue.org.au

- The *Better Access to Psychiatrists, Psychologists and General Practitioners through the Medicare Benefits Schedule* (Better Access) initiative, the aim of which is to provide access for people with an assessed mental disorder to mental health care by General Practitioners (GPs), psychiatrists, psychologists and appropriately trained social workers and occupational therapists. Eligible individuals may access up to 12 individual and 12 group allied mental health services in a calendar year, and up to 6 additional individual sessions in exceptional circumstances.

  To be eligible to access Medicare rebates for mental health services with a psychologist, social worker or occupational therapist, an individual must be referred by a GP (who is managing that person under a GP Mental Health Treatment Plan), or a psychiatrist or pediatrician in private practice. A GP Mental Health Treatment Plan is intended to provide a GP with a framework for assessing a patient and discussing their treatment options. As part of the development of a GP Mental Health Treatment Plan, it is necessary for a GP to undertake an assessment of the patient that includes examination of possible physical, social and psychological issues.

- The *Mental Health Services in Rural and Remote Areas* Program, which funds allied and nursing mental health services in rural and remote communities throughout Australia. Funding is provided to Divisions of General Practice, Aboriginal Medical Services and the Royal Flying Doctor Service to auspice the delivery of mental health services. Appropriately trained mental health care workers include psychologists, social workers, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers. The Program is designed to address inequities in access to the Medicare Benefits Schedule (MBS) by targeting areas where access to MBS subsidised mental health items is low.

- The Access to Allied Psychological Services (ATAPS) component of the Better Outcomes in Mental Health Care (BOIMHC) Program enables General Practitioners to refer patients, who have been diagnosed as having a mental disorder, to appropriately qualified mental health professionals who deliver focused psychological strategies. The ATAPS initiative, which is funded through Divisions of General Practice across Australia, primarily treats high prevalence mental health disorders such as anxiety and depression. Eligible individuals may access up to 12 individual and 12 group allied mental health services in a calendar year, and up to 6 additional individual sessions in exceptional circumstances

The Australian Government also provides funding to a number of non-government organisations under the Council of Australian Government (COAG) Telephone Counselling, Self Help and Web-based Support Programmes initiative.

This initiative aims to increase the provision of evidence based telephone and web-based counselling services, and expand and enhance on-line interactive tools, increasing the availability of these services to individuals with common mental health disorders or in psychosocial crisis who currently receive limited or no treatment.

Patients experiencing depression due to poor vision can access the following national telephone counselling services and support around the clock:

- Lifeline Australia is funded to support the development of a national referral database for mental health services, increase telephone counselling services and improve the quality of service for mental health callers. Lifeline also provides a free, confidential and anonymous, 24-hour telephone counselling service for adults.

- Kids Help Line is a free, confidential and anonymous, 24-hour telephone counselling service specifically for young people aged between 5 and 25 years. Kids Help Line also offers a ‘limited hours’ online counselling service. Professional counsellors are available to respond to telephone and online contacts and young people are able to build up a relationship with a specific counsellor.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-231

OUTCOME 11: Mental Health

Topic: MENTAL ILLNESS IN RURAL AREAS

Written Question on Notice

Senator Adams asked:

There are many challenges relating to mental illness in rural areas, what plans, if any, are there to go work with schools to ensure prevention and early intervention for younger people?

Answer:

The Australian Government funds school based mental health initiatives nationally which are available to schools in rural areas.

MindMatters is a secondary school based mental health promotion, prevention and early intervention initiative which commenced in 2000. Since its introduction, staff from over 80% of secondary schools have participated in MindMatters professional learning to assist raising awareness of mental health issues, with over 50% of secondary schools continuing to use MindMatters as a key curriculum resource. These schools cover a broad geographic spread including rural areas.

The KidsMatter Primary mental health promotion, prevention and early intervention initiative was piloted from 2006 - 2008 in 101 primary schools nationally including a number of rural schools. Consultation has occurred with education representatives from Government and the Catholic and Independent education sectors in all states and territories regarding trialling a national roll out of KidsMatter Primary.

In addition to the above, a new project has been funded under the auspice of the Australian Child and Adolescent Trauma, Loss and Grief Network and Principals Australia to support children attending schools in rural Victoria affected by the bushfire. This was developed in consultation with the Department of Human Services, Victoria and the Department of Education and Early Childhood Development, Victoria and will support up to 75 schools.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-340

OUTCOME 11: Mental Health

Topic: LEADERSHIP IN MENTAL HEALTH REFORM

Senator Humphries asked:

a) What key priorities are being focused on and from where precisely will that money be taken?

b) Describe to me what program has been cut by $20 million please?

Answer:

a and b)

The Leadership in Mental Health Reform (LIMHR) funds will support Commonwealth activities which are largely national and which the Commonwealth leads, but in which states and territories also participate. The LIMHR measure is a continuation of funding formerly linked to the Australian Health Care Agreements (AHCAs), also known as Commonwealth Own Purpose Outlays (COPO) on Mental Health Reform. The LIMHR is a new appropriation to replace the COPO program.

Originally the continuation of the COPO was allocated $66.6 million over four years in the forward estimates. As part of the 2009-2010 Budget, savings of $20 million over four years ($5 million per annum) have been made to the forward estimates for this measure.

The LIMHR funding will support the implementation of the Government's commitment to ongoing national leadership and accountability in mental health by promoting:

- evidence based mental health policy and planning through the continuation of national population mental health surveys, research and analysis;
- accountability and transparency of governments and services to the community through existing and future reporting mechanisms such as the annual COAG Action Plan on Mental Health (2002-2011) reports, the National Mental Health Report and the Mental Health Services in Australian Report as well as ongoing data development, collection and analysis activities via the Australian Institute of Health and Welfare (AIHW) and established reporting partnerships with states and territories;
- ongoing quality and safety improvements in mental health services, for example, via the implementation of the revised National Mental Health Standards; and
- support for consumer participation and NGOs in the mental health reform policy and program development.

These are Commonwealth led activities which are focussed on supporting reforms in mental health. While there has been a reduction in funding the Department has worked to ensure that key priorities that support improvements in mental health policy and programs will continue. This includes support for continuing improvements in the safety and quality of

mental health services, as will ongoing support for national peak bodies and for consumer and carer representation within policy and program development. Some work around the improvement of data and performance indicators and measures may proceed more slowly.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-296

OUTCOME 11: Mental Health

Topic: ELECTROCONVULSIVE THERAPY (ECT)

Senator Boyce asked:

a) How many Australians were treated with Electroconvulsive Therapy in the financial year 2007-08, broken down to each State and Territory?

b) At which facilities were these ECT treatments administered?

Answer:

a) The Australian Government can provide information on services provided to patients, for which a Medicare benefit was claimed. The following response excludes any services that may have been provided either to private patients who may have chosen not to submit a claim for Medicare benefits, or to public patients for whom state and territory governments are responsible.

In the 2007-08 financial year, 1,946 patients in Australia claimed benefits for Medicare item 14224 (Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation).

The table below represents the jurisdictional breakdown of the number of patients based on the patient's postcode. Please note that if patients move from one jurisdiction to another during the financial year, they are recorded in each jurisdiction. Therefore, the total of the table below (1,956 patients) is greater than the total number of patients who claimed benefits over the period in question. For confidentiality reasons, ACT figures are combined with NSW and NT figures with SA.

NSW and ACT	Vic	Qld	SA and NT	WA	Tas
521	535	468	126	212	94

b) The Department considers that it may not be in the public interest to disclose the information sought in response to this question, on the following grounds.

Medicare benefits are derived on the basis of the provision of a service by an eligible provider (clinician) to an eligible patient. Medicare data is definitive in recording the identities of these two parties to any one claim, but the identity of the facility at which the service is provided is not required under regulation 13 of the *Health Insurance Regulations 1975* and is not recorded consistently. Therefore, information about facilities at which ECT services were provided, and for which Medicare benefits were claimed, would be speculative and potentially misleading.

Further, without information substantiating that disclosure is necessary in the public interest, the Department does not release information derived from Medicare data that potentially would identify an individual patient, provider or facility. The Department is guided in these circumstances by the secrecy provisions (s.130) of the *Health Insurance Act 1973*, and 'Guidelines for the release of information where necessary in the public interest,' approved by the Secretary in June 2003.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-297

OUTCOME 11: Mental Health

Topic: ELECTROCONVULSIVE THERAPY (ECT)

Written Question on Notice

Senator Boyce asked:

a) According to Medicare data, how many Queenslanders were treated with ECT without their consent?
b) Which facilities were these treatments administered?

Answer:

a) Medicare data does not contain information distinguishing voluntary from involuntary use of health services.

b) Medicare data does not contain information distinguishing voluntary from involuntary use of health services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-298

OUTCOME 11: Mental health

Topic: ELECTROCONVULSIVE THERAPY (ECT)

Written Question on Notice

Senator Boyce asked:

How many patients treated with ECT were less than 14 years of age and can the Department provide these figures broken down for each State and Territory?

Answer:

In 2007-08, which is the latest financial year data available, there were no recorded electroconvulsive therapy treatments in Medicare data for patients less than 14 years of age.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-299

OUTCOME 11: Mental Health

Topic: ELECTROCONVULSIVE THERAPY (ECT)

Senator Boyce asked:

What has been the increase or decrease in the number of patients in each State and Territory treated with ECT in the years between 2000-01 and 2007-08?

Answer:

The Australian Government can provide information on services provided to patients, for which a Medicare benefit was claimed. The following response excludes any services that may have been provided either to private patients who may have chosen not to submit a claim for Medicare benefits, or to public patients for whom state and territory governments are responsible.

The number of patients claiming benefits for MBS item 14224 (Electroconvulsive therapy, with or without the use of stimulus dosing techniques, including any electroencephalographic monitoring and associated consultation) by financial year and jurisdiction of the patient are as follows:

Year	NSW and ACT	Vic	Qld	SA and NT	WA	Tas	Australia*
2000/01	403	391	362	140	111	77	1476
2001/02	432	409	399	126	120	76	1560
2002/03	444	467	436	132	142	62	1677
2003/04	450	415	405	151	154	66	1631
2004/05	433	469	411	131	155	69	1660
2005/06	576	482	429	130	183	62	1861
2006/07	496	512	473	134	191	70	1871
2007/08	521	535	468	126	212	94	1946

* Please note that if patients move from one jurisdiction to another during the financial year, they are recorded in each jurisdiction. Therefore, in the table above, the totals are greater than the total number of patients who claimed benefits over the period in question as reflected in the totals provided in the Australia column of the table.

For confidentiality reasons, ACT figures are combined with NSW and NT figures with SA.

Australian Government

Department of Health and Ageing

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphery

Request for Amendment to Evidence Provided at Community Affairs Senate Estimates Hearing,
4 June 2009: Outcome 12

I am writing to correct a statement that I made at the June 2009 Estimates of the Senate Community Affairs Committee on 4 June 2009.

Senator Xenophon asked a series of questions about representations made by residents of Gawler:

"I have been contacted by constituents in Gawler in relation to the proposed changes to the classification of Gawler. There is a significant concern that that change in classification will mean a substantial diminution in health services in that area and community and for the communities that they service. Dr Anthony Page, who is one of the doctors in GP Inc. at Gawler, says that, in April, the federal Department of Health and Ageing was in town saying that the model used in Gawler should be adopted in other regions. But, he says, only weeks later the same department pulled the rug out from under their feet. Firstly, can you comment on the changes that are proposed. Secondly, is it the case that the department as recently as April was saying that this was a very good model in terms of provision of healthcare services, and what assessment has been undertaken as to the potential impact of this change on the residents of Gawler and surrounding areas?" (CA141)

My response included the following statement:

"I spoke to the principal in the order of a week ago, and I know that many of my departmental colleagues have done likewise—that is, spoken to the principal of that organisation and others who have shared those concerns—and it seems that there is a period of appeasement and then we have these concerns rebuilding. They are quick to point out that it has taken some considerable time and effort to have the geographical classification under RRMA—it did take some time to have that changed—and what this represents is a reversion to that urban status that was initially under RRMA, and now the township of Gawler is again considered to be urban, albeit under a new geographical classification system by virtue of its size and its proximity to large urban centres such as Elizabeth, Salisbury and surrounds, which I have no doubt you are familiar with.

I guess, in summary, we are talking about a very small number of practitioners. Specifically, we are talking about three registrars who are presently in situ in placements in Gawler, who will be grandparented throughout their registrar training period so that they will suffer no financial detriment whatever. In relation to the HECS Reimbursement Scheme, there are no present recipients of the HECS Reimbursement Scheme in Gawler. Nonetheless, under the changes, Gawler will no longer be an eligible area for

individuals to participate in the HECS Reimbursement Scheme. The other program of interest is the Rural Retention Program. No individuals will be affected there. There are two programs where Gawler will be affected primarily. One is the Rural and Remote General Practice Program, and that is where rural workforce agencies assist in the recruitment and retention of doctors, primarily overseas trained doctors, in what are deemed rural areas.

Previously, upon Gawler having its geographic classification overturned and being deemed rural, practices in that area were entitled to receive assistance from those agencies in the attraction and retention of, primarily, overseas trained doctors. Under the new system, practices will no longer have that entitlement. The second program which will change, in terms of the eligibility of doctors in the township, is the Training for Rural and Remote Procedural GPs Program and, as Ms Bennett has outlined, all present recipients will continue to receive a financial benefit for their participation in the program." (CA142)

I note the specific reference:

..."we are talking about three registrars who are presently in situ in placements in Gawler, who will be grandparented throughout their registrar training period so that they will suffer no financial detriment whatever."

The response was accurate based on the information available at that time. It has been brought to my notice that this statement is incorrect. I wish to correct the statement and provide the following evidence to the Committee:

- General Practice Registrars participating in the Australian General Practice Training Program may undertake their training in two streams – 'general' and 'rural'.
- When Gawler's classification was changed to RRMA 4 (Rural), practices in Gawler were eligible to seek the services of registrars on the rural pathway as well as those on the general pathway.
- Upon changing from the RRMA classification system to the Australian Standard Geographic Classification – Remoteness Areas (AGSC-RA) system, Gawler is reclassified to ASGC-RA 1 (Major cities) and will lose access to rural registrars but retain access to general pathway registrars. As access to registrars will continue for Gawler there will be no grandparenting arrangements for rural pathway registrars.

Yours sincerely

David Dennis
Assistant Secretary
Workforce Distribution Branch

22 June 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-101

OUTCOME 12

Topic: Medical Workforce Distribution

Hansard Page: Written Question on Notice

Senator Nash asked:

a) What modelling has the Department undertaken in relation to medical workforce distribution changes that they expect from the change to ASGC-RA and changes in the retention and relocation payments that will be made to doctors?
b) Will this modelling be made available to the profession?

Answer:

a) The budget impact of changes to retention and relocation incentives announced as part of the move to the ASGC-RA classification system was modelled in the course of the budget process using the Department's existing data holdings for the current Rural Retention Program.

b) The modelling was developed as part of policy formulation in the budget process. Consistent with usual practice, the modelling will not be made publicly available.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-069

OUTCOME 12: Health Workforce Capacity

Topic: MENTAL HEALTH SCHOLARSHIPS AND GRADUATES IN RURAL AREAS

Written Question on notice

Senator Williams asked:

a) What is being done to attract appropriate staff to rural areas such as scholarships for rural students and new graduates in the mental health field?
b) How are these issues going to be addressed?

Answer:

a) Mental Health Services in Rural and Remote Areas program
The Australian Government has committed $91 million (2006-07 to 2012-13) to the Mental Health Services in Rural and Remote Areas Program (the Program), which provides funding for more allied and nursing mental health services to be provided in rural and remote communities throughout Australia.

Funding is provided to Divisions of General Practice, Aboriginal Medical Services and the Royal Flying Doctor Service to auspice the delivery of mental health services. Appropriately trained mental health care providers eligible under the Program include psychologists, social workers, occupational therapists, mental health nurses, Aboriginal health workers and Aboriginal mental health workers.

The Program addresses workforce shortage issues by providing flexible employment models suited to local needs and conditions, including job-share arrangements, outreach services, locally contracted positions and 'fly-in, fly-out' services. Other Commonwealth measures designed to increase the mental health workforce, such as scholarships and increasing mental health content in undergraduate health science courses, complement this program.

Scholarships

The Australian Government funds a range of programs to assist students or practising allied health professionals to undertake allied health degrees, clinical placements or continuing professional development opportunities. Generally these schemes are focused on rural and remote areas of Australia, where access to health professionals is more limited. These schemes include the Mental Health Postgraduate Scholarship Scheme, outlined below, as well as the Rural Allied Health Undergraduate Scholarship Scheme, the Australian Rural and Remote Health Professional Scholarship Scheme, the Allied Health Clinical Placement Scholarship Scheme and the Puggy Hunter Memorial Scholarship Scheme.

The Mental Health Postgraduate Scholarship Scheme

The Mental Health Postgraduate Scholarship Scheme aims to increase Australia's trained mental health workforce by supporting people to undertake postgraduate studies in clinical psychology and mental health nursing.

In the 2008-09 Budget, the Government committed an additional $35 million over four years to increase the value and availability of clinical psychology and mental health nursing scholarships under the Mental Health Postgraduate Scholarship Scheme, including around 100 designated rural and remote scholarships for mental health nursing over four years.

For the 2009 academic year, 40 full-time-equivalent scholarships were awarded to people from a rural or remote area to undertake postgraduate mental health nursing studies, equating to 65 people when taking into account those studying part-time. This was over 16% of the total mental health nursing scholarships awarded for 2009.

b) The Australian Government is addressing the issue of health workforce shortages in rural and regional areas through continued support of programs such as those outlined above and through a range of other strategies such as:
   - the Australian Government's $1.1 billion commitment to a new health workforce package agreed to by COAG in November 2008, which includes funding for undergraduate and postgraduate clinical training, clinical supervisor training, health workforce capital infrastructure and the establishment of a national health workforce agency; and
   - the Australian Government's $134.4 million Rural Health Workforce Strategy announced in the 2009-10 Budget.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-321

OUTCOME 12: Health Workforce Capacity

Topic: TRACKING OF MENTAL HEALTH SCHOLARSHIPS

Senator Humphries asked:

We were told that there was $35 million provided over four years for 1,070 postgraduate masters degrees scholarships and mental health nurses, 100 of which were targeted to rural or remote areas. ….Are you tracking to achieve that target at this point in time?

Answer:

The program is currently on track to achieve these targets, with 61 Full-Time Equivalent (FTE) clinical psychology scholarships and 40 FTE mental health nursing scholarships allocated to people from rural and remote areas as at 7 July 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-322

OUTCOME 12: Health Workforce Capacity

Topic: AGE OF RURAL AND REMOTE DENTISTS

Hansard Page: CA94

Senator Williams asked:

I just want to touch on that, if I could please, Mr Groth. One of the concerns I have is the average age of dentists, we are talking of a specialist field. My concern is that in regional areas, of those 19.8 or 28.5, those bottom two figures you gave me, that many of those dentists—figures I have had given to me is up to 45 per cent—are soon to retire in the next five or six years. Are you tracking the actual age of those dentists? In other words, to get an idea of where how much of their working life in their profession is still there?

Answer:

The Department monitors information on the age of dentists. Data on dentists in Australia are collected and collated by the Dental Statistics and Research Unit (DSRU), a collaborating unit of the Australian Institute of Health and Welfare (AIHW) located in the Australian Research Centre for Population Oral Health at the University of Adelaide.

Data are disaggregated by the Australian Standard Geographical Classification – Remoteness Area tool, which was developed by the Australian Bureau of Statistics for the collection and dissemination of geographically classified statistics.

The following presents data from the AIHW/DSRU Dental Labour Force Survey, 2005, which is the most recent data collection available.

The average age of dentists in 2005 by remoteness

Remoteness area of main practice	**Average age (years)**
• Major cities	44.3
• Inner regional	45.3
• Outer regional	45.2
• Remote and Very Remote	41.6
• **Australia**	**44.5**

The average age of dentists across Australia has remained fairly stable in recent years: 44.4 years in 2000, 44.6 years in 2003 and 44.5 in 2005.

In 2005 there were an estimated 10,074 dentists practising in Australia, of which 2,223 were aged 55 or over. This represents around 22% of the total number practising in Australia. This figure is broken down by region of practice as follows.

Number of practising dentists aged 55 or over in 2005 by remoteness

Remoteness area of main practice	Total number	Number aged 55 or over	Percentage %
• Major cities	7,889	1,689	21.4
• Inner regional	1,488	366	24.6
• Outer regional	591	144	24.4
• Remote and Very Remote	100	24	24.0
• **Australia**	**10,074***	**2,223**	**22.1**

The data show that the proportion of dentists aged 55 or over is roughly comparable across all regions, but slightly higher outside of major cities.

* DSRU notes that a small number of specialists who did not respond in the NT survey have been included in the overall total, but not the totals within remoteness area. This is why the overall total is slightly higher than the components add up to.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 4 June 2009

Question: E09-335

OUTCOME 12: Health Workforce Capacity

Topic: MENTAL HEALTH NURSE INCENTIVE PROGRAM

Hansard Page: CA 85

Senator Humphries asked:

a) Could I have, please, what was originally envisaged to be the full-time equivalent number of nurses in this program over the five years?
b) What is the actual number of nurses—and I would like each of these figures in full-time equivalent and actual number—in the program at the moment and how many you anticipate

Answer:

a and b)

The Mental Health Nurse Incentive Program is a demand driven Program. Funding is not limited to a set number of mental health nurses to participate in the Program over the five year period.

However, as at 31 May 2009, 437 mental health nurses have been engaged in the Mental Health Nurse Incentive Program. The Department does not have data on full time equivalent basis for mental health nurses participating in the Program. However, given the sessional nature of the work and the fact some participating nurses are in shared employment arrangements, a proportion of nurses participating in the program are likely to be engaged on a part time basis.

Uptake of the program was initially slow. However uptake increased significantly from the beginning of 2008. The increase was a result of a number of enhancements to the Program which aimed to increase access to mental health nurse services, including allowing mental health nurses to enter into employment arrangements so that their skills could be shared between state health organisations and participating practices.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-301

OUTCOME 12: Health Workforce Capacity

Topic: SCHOLARSHIPS AND TRAINING PROGRAMS

Written Question on Notice

Senator Boyce asked:

The government plans to streamline scholarships and training programs for health professionals. Can the Department explain why a streamlined process will not result in an increase in the number of undergraduate health and dental students by 2013?

Answer:

The number of undergraduate health and dental students are not determined by scholarship numbers. Figure 2 on page 305 of the Health and Ageing Portfolio, Portfolio Budget statements 2009-10 illustrates the estimated increase in the number of students enrolled in health professions up until 2013. The estimates are based on Department of Education, Employment and Workplace Relations administrative data. Heath education place numbers are determined by a range of factors, including demand and funding arrangements. These issues are the responsibility of the Department of Education, Employment and Workplace Relations.

As part of the 2009-10 Budget measure, a range of nursing and allied health scholarships and support programs will be consolidated into one scheme.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-015

OUTCOME 12: Health Workforce Capacity

Topic: COSMETIC SURGEONS

Written Question on Notice

Senator Ryan asked:

How many complaints have been received per year over the last two years, against cosmetic surgeons in:

a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?

Answer:

a– h)

Complaints against medical practitioners are a matter for the relevant state or territory health complaints authority. The Department of Health and Ageing does not hold data on complaints against cosmetic surgeons.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-238

OUTCOME 12: Health Workforce Capacity

Topic: BRINGING NURSES BACK INTO THE WORKFORCE

Written Question on Notice

Senator Adams asked:

Have you received feedback from employers as to the success of nurses re-entering the workforce?

Answer:

The Department welcomes feedback on the Bringing Nurses Back into the Workforce (BNBW) Program from employers and nurses through BNBW Participants or directly to the Department. A specific email address and phone number have been established within the Department for the BNBW Program. General issues identified in feedback have included questions about restrictions on eligibility criteria, and a lack of promotion of the program. Referral arrangements are in place that direct people to the dedicated hotline. As part of the routine progress reports, BNBW fund holders identify issues that impact on the success of the Program this includes the feedback that they receive from employers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-240

OUTCOME 12: Health Workforce Capacity

Topic: NURSES RE-ENTERING THE WORKFORCE

Written Question on Notice

Senator Adams asked:

Can you provide information as to how you are attracting young people to nursing, as it is known that this is an ageing workforce?

Answer:

The Government allocated an additional 1134 Commonwealth supported nursing education places in 2009 and these places will be ongoing. The increased nursing places will help increase the number of nurses entering the workforce in future years.

In addition, a range of training and support initiatives to assist nurses to enter the field or develop their qualifications are funded. These programs include scholarships for undergraduate training, continuing professional development and re-entry training.

Other Government initiatives such as the 2009 – 2010 Nurse Practitioner and Midwives Scholarship budget measure will enhance the role and recognition of nurses and enhance possible career paths which may assist in the recruitment and retention of highly skilled nurses in the future.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 3 & 4 June 2009

Question: E09-300

OUTCOME 12: Health Workforce Capacity

Topic: NURSING PLACES

Written Question on Notice

Senator Boyce asked:

The PBS states that the student enrolments for undergraduate medical and dental courses are expected to remain reasonably constant between 2009 and 2013. However, nursing is expected to rise by 3000 places from 2009 to 2010, before rising by 1000 in the next 2 years and falling between 2012 and 2013. Can the Department outline why nursing places are expected to fall after 2012?

Answer:

The Health and Ageing Portfolio Budget Statements 2009-10 includes a figure on the '*Estimated Increase in the Numbers of Student Enrolment in Health Profession*' (Figure 2, page 305), sourced from the Department of Education, Employment and Workforce Relations. It does not indicate that estimated enrolments decrease after 2012, but rather that enrolments are expected to stay at that level in 2013.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 4 June 2009

Question: E09-323

OUTCOME 12: Health Workforce Capacity

Topic: NURSE PRACTITIONERS

Hansard Page: CA 96

Senator Adams asked:

How many nurse practitioners have we got physically working in rural areas at the present time?

Answer:

There is currently no definitive data on the location of nurse practitioners nationally. Some jurisdictions have indicated that around 5% of their nurse practitioners specialise in rural and remote heath. However, this may not reflect rural based nurse practitioners who may be practising in other specialty areas.

The introduction of the national registration and accreditation scheme, from 1 July 2010, will improve the available data on the distribution of the health workforce, including nurse practitioners.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-035

OUTCOME 12: Health Workforce Capcity

Topic: DOCTOR SHORTAGE

Written Question on Notice

Senator Ryan asked:

a) Has the Department quantified a doctor shortage? If so, how many doctors are required to meet desired levels or targets in:
b) Victoria?
c) New South Wales?
d) Queensland?
e) South Australia?
f) Western Australia?
g) Tasmania?
h) ACT?
i) NT?

Answer:

a) The Australian Government has not set levels or targets on the number of doctors required in each state and territory. It is, however, aware that there are shortages of doctors in some areas. This is addressed in two ways – through programs that address the distribution of doctors and through ensuring an increased supply of doctors into the future.

   Areas of Workforce Shortage are identified by the Australian Government and are used as the basis for restrictions on where overseas trained doctors are able to work. Any community is assessed as being an Area of Workforce Shortage if there is less access to medical services than that experienced by the population in general. This is calculated by comparing the ratio of full-time workload equivalent general practitioners to a population in a given area to that of the national average.

b – i)

The most recent data available on doctor to population ratios by state/territory is for March - June 2009. The figures in the table below show the ratio of population to FTE GPs by State and Territory.

Ratio of Population to FTE GP by State/Territory for March - June 2009

Year	NSW	VIC	QLD	SA	WA	TAS	NT	ACT
March 2008	1262	1287	1190	1217	1434	1355	1804	1604

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-036

OUTCOME 12: Health Workforce Capacity

Topic: MEDICAL STUDENT GRADUATES

Written Question on Notice

Senator Ryan asked:

a) How many medical students will graduate from Australian universities in each of the next ten years?
b) What is the expected delay between a medical graduate successfully completing and leaving university and entering the medical workforce as a: i) General Practitioner; ii) Medical Specialist?
c) What percentage of these medical graduates is projected to enter the medical workforce as either a general practitioner or medical specialist with a Medicare Provider Number within: i) five years of graduation; ii) ten years of graduation?

Answer:

a) Projections on the number of medical student graduates from Australian universities are available from 2008 to 2012 and can be sourced from the Medical Training Review Panel (MTRP) Twelfth Report. Projections beyond 2012 are not available.

The projected numbers from the 12th MTRP report are as follows:

Year	2008	2009	2010	2011	2012
Number of medical student graduates	2,243	2,442	2,647	3,112	3,437

Source: Medical Training Review Panel (MTRP) 12th Report, 2009

b) It typically takes around six to eleven years from the time a student graduates university to the completion of a vocational training program to become a medical specialist, including general practitioners (GPs). The minimum timeframes for medical qualifications, including university training, are outlined in the following table.

Typical minimum timeframes for medical qualifications

Stage of training	Number of years for each stage of training	Cumulative number of years training
Medical student (4-6 year medical degree)	4 - 6 years	4 - 6 years
Intern (post graduate year 1)	1 year	6 - 7 years
General Registration		
Junior/resident medical officer (post graduate year 2)	1 year	7 - 8 years
Senior medical officer (post graduate year 3 + 4)	2 years	8 - 10 years
Specialist trainee/registrar (4 - 6 years Medical Specialist Degree)	4 - 6 years	8 - 16 years
Medical Specialist		12 - 17 years
Sub-specialty training		12 - 17 + years

Adapted from: Australian Government Department of Health and Ageing (2008). *Report on the Audit of Health Workforce in Rural and Regional Australia*, p30.

c) At this point in time there are no projections available of when medical graduates will enter the workforce as independent fully qualified specialists eligible to access Medicare items. To complete the required prevocational and vocational training to specialise it takes a minimum of:
   i) four years to fully qualify as a general practitioner; and
   ii) eight years for other medical specialists.

.Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-037

OUTCOME 12: Health Workforce Capacity

Topic: HOSPITAL TRAINING PLACES

Written Question on Notice

Senator Ryan asked:

How many hospital training places will be available in each of the next 10 years?

Answer:

The Department does not hold data on the number of hospital training places that will be available in the next ten years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-178

OUTCOME 12: Health Workforce Capacity

Topic: SPECIALIST TRAINING IN RURAL AREAS

Hansard Page: CA 98

Senator Cormann asked:

a) There are only very few specialist training positions in regional areas, are there not?
b) Is there anything planned in terms of specialist training positions in regional areas?

Answer:

a and b)
There are two Programs that currently support specialist trainees that are available to rural settings:

The Expanded Specialist Training Program (ESTP):
ESTP contributes funding towards registrar training rotations in settings beyond traditional public teaching hospitals, such as private hospitals, community settings, doctors' rooms and simulated learning environments.

For the 2009 calendar year there are approximately 240 specialist training positions funded under ESTP nationally. Of these, 98 positions contain a regional, rural or remote rotation.

The Advanced Specialist Training Posts in Rural Areas (ASTPRA) Program:
ASTPRA is a cost shared Program with States and the Northern Territory to fund accredited advanced specialist training posts in rural and remote areas.

For the 2009 calendar year there are approximately 39 specialist training positions funded nationally, all of which contain a regional, rural or remote focus.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-232

OUTCOME 12: Health Workforce Capacity

Topic: MEDICAL WORKFORCE

Written Question on Notice

Senator Adams asked:

Will the new health workforce agency be responsible for tracking health professionals in all disciplines in order to see where deficits are and which incentive programs are successful?

Answer:

Health Workforce Australia's responsibilities will include funding, planning and coordinating pre-professional entry clinical training across all health disciplines; supporting health workforce research and planning, including through a national workforce planning statistical database.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-241

OUTCOME 12: Health Workforce Capacity

Topic: NATIONAL HEALTH WORKFORCE AGENCY

Written Question on Notice

Senator Adams asked:

a) Can you provide the budget breakdown for establishing the National Health Workforce Agency?
b) Do you as yet have details as to the representatives on this agency?
c) Will there be a template as to the KPIs for this agency?

Answer:

a) $125 million over four years has been allocated from solely Commonwealth appropriations to fund the new agency, Health Workforce Australia (HWA). A further breakdown of costs of implementation will be available following the appointment of the Chief Executive Officer.

HWA will administer the following elements of the National Partnership Agreement on Hospital and Health Workforce Reform:

	2009-10	2010-11	2011-12	2012-13	Total
	$m	$m	$m	$m	$m
Clinical training – undergraduate subsidy	135.0	280.5	287.3	290.1	992.9
Clinical training – expanded supervision capacity	8.0	12.0	16.0	20.0	56.0
Clinical training – expanded use of simulated learning	0.5	14.9	40.0	41.5	96.9
Health workforce policy and planning	20.0	30.0	15.0	6.0	71.0
National workforce planning statistical database	1.5	1.6	1.1	1.4	5.5
Total	165.0	339.0	359.4	359.0	1222.4

b) Specific details of the representatives on the board have not yet been determined.

The HWA Board will comprise the following:
- the Chair;
- eight members nominated by state and territory jurisdictions;
- one member nominated by the Commonwealth; and
- Up to three additional members.

The Minister for Health and Ageing will call for nominations from relevant stakeholders to fill the non-government positions of the board. Under the Health Workforce Australia legislation, the nominations will be considered by the Ministerial Conference of the Commonwealth, state and territory health ministers. The final appointments will need to be approved by the Commonwealth Cabinet.

The government-nominated members are expected to be the CEOs of the respective health departments.

The recruitment process for the Chief Executive Officer has commenced.

c) Key performance indicators (KPIs) will be developed to assess and monitor the performance of HWA. These KPIs will be in addition to the mandatory reporting requirements under the *Commonwealth Authorities and Companies* (CAC) *Act*. That Act deals with matters relating to Commonwealth authorities, including reporting and accountability, banking and investment, and conduct of officers.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2008-2009, 4 June 2009

Question: E09-324

OUTCOME 12: Health Workforce Capacity

Topic: BRINGING NURSES BACK INTO THE WORKFORCE

Hansard Page: CA 98-99

Senator Adams asked:

a) How many nurses have re-entered the workforce as part of the Bringing Nurses Back into the Workforce 2008 budget measure?

b) How many nurses have received the six month $3,000 payment but not continued with their employment contracts?

c) Have you had any problems with that?

d) Have you received feedback from employers as to the success of nurses re-entering the workforce?

e) Has there been any follow-up in that respect?

Answer:

a) Based on the latest reported data, 440 nurses are known to have returned to the nursing workforce in public and private hospitals under the Bringing Nurses Back into the Workforce (BNBW) Program.

b) Latest reported data indicates that seven nurses have withdrawn from the Program after at least six months of continuous employment. These nurses received a pro rata bonus payment in respect of their six months employment, in line with the Program guidelines.

c) See answer to b) above.

d) The Department welcomes feedback on the BNBW Program from employers and nurses through BNBW Participants or directly to the Department. A specific email address and phone number have been established within the Department for the BNBW Program. General issues identified in feedback have included questions about restrictions on eligibility criteria, and a lack of promotion of the Program. Referral arrangements are in place that direct people to the dedicated hotline. As part of the routine progress reports, BNBW fund holders identify issues that impact on the success of the program this includes the feedback that they receive from employers.

e) Feedback on the Program contributed to expanded eligibility criteria which included nurses returning to day surgery hospitals and community health settings from December 2008, and a national promotional campaign which has resulted in an increase in interest in the Program.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates June 2009-2010, 4 June 2009

Question: E09-337

OUTCOME 12: Health Workforce Capacity

Topic: GENERAL PRACTITIONERS

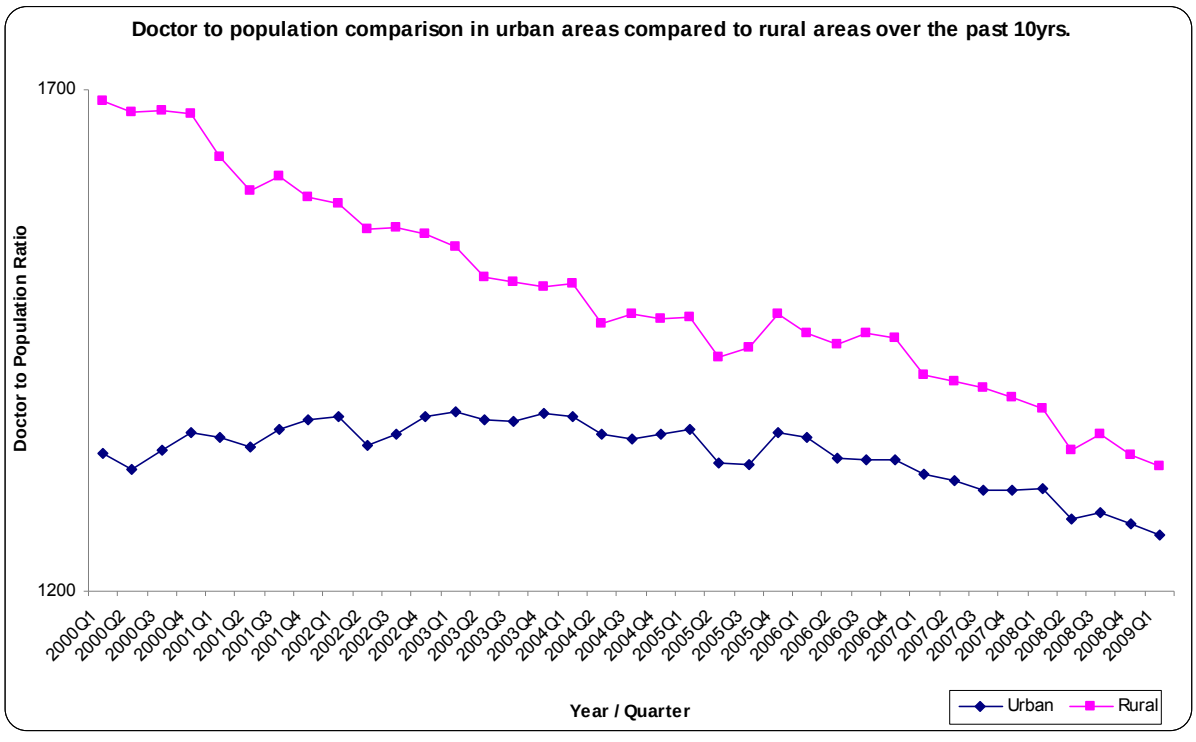
Hansard Page: CA 91

Senator Williams asked:

Comparison between GPs per capita in urban areas compared to GPs per capita in rural areas – past 10yrs

Answer:

The *Report on the Audit of Health Workforce in Rural and Regional Australia* found that the supply of health professionals in many rural and regional centres is low to very poor and compares poorly to major cities. This is consistent with assumptions made that workforce shortages of medical practitioners are worse in rural and remote areas. The table below shows the doctor to population comparison in urban areas compared with rural areas over the past ten years.



Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-033

OUTCOME 12: Health Workforce Capacity

Topic: OVERSEAS-TRAINED DOCTORS

Written Question on Notice

Senator Ryan asked:

How many overseas trained doctors are practising in Australia by country of origin in:

a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?

Answer:

a – h)

Medicare statistics are not available on overseas trained doctors by country of origin, but they are available by place of base qualification.

Details of the number of doctors who rendered or requested services under Medicare in calendar year 2008 (year of service) and with a place of base qualification of 'overseas', are presented in the attached table.

Some practitioners practised under Medicare in more than one state or territory. Each practitioner was allocated to his or her major state or territory, having regard to the volume of services rendered and requested in each state or territory.

Where the number of practitioners for individual countries at state/territory level was small, the countries in question were grouped by region, for confidentiality reasons. Furthermore, for confidentiality reasons statistics for the Northern Territory have been included with South Australia and statistics for the Australian Capital Territory have been included in New South Wales.

These statistics do not include overseas trained doctors who may have practised in Australia, for example, in public hospitals, who did not render or refer patients under Medicare.

Some doctors who have practised at many locations have multiple provider stem numbers. To the extent that some doctors claimed under more than one provider stem number, there will be some multiple counting of doctors.

MEDICARE - NUMBER OF OVERSEAS TRAINED DOCTORS
WHO RENDERED AND OR REQUESTED SERVICES UNDER MEDICARE
BY PLACE OF BASE QUALIFICATION AND BY MAJOR STATE/TERRITORY OF PROVIDER
2008 (YEAR OF SERVICE)

COUNTRY	NSW & ACT	VIC	QLD	SA & NT	WA	TAS	AUSTRALIA
BANGLADESH	130	48	85	19	13	17	312
BURMA	83	21	72	7	25	8	216
CHINA	97	151	58	23	20	2	351
EASTERN EUROPEAN	101	89	66	22	20	10	308
EGYPT	320	183	77	23	27	6	636
ENGLAND	996	828	1,012	346	823	158	4,163
GERMANY	155	144	153	48	68	28	596
HONG KONG	139	41	6	15	22	-	223
INDIA	1,167	812	748	446	308	125	3,606
IRAN	42	61	104	15	9	14	245
IRAQ	92	63	25	13	15	7	215
MALAYSIA	64	44	15	60	30	-	213
EAST ASIA	23	27	10	n.a.	7	n.a.	73
NETHERLANDS	40	34	76	25	59	8	242
NEW ZEALAND	645	411	522	122	221	53	1,974
NIGERIA	18	29	31	16	42	11	147
NORTHERN AMERICA	125	86	97	34	30	9	381
NORTHERN IRELAND	58	59	70	14	56	10	267
OTHER AFRICAN	22	32	8	18	20	2	102
OTHER AMERICAS	51	59	71	12	21	4	218
OTHER ASIA	147	143	73	34	23	3	423
OTHER EUROPEAN	116	136	77	48	68	6	451
OTHER PACIFIC	27	16	77	12	7	6	145
PAKISTAN	131	93	144	70	41	11	490
PHILIPPINES	96	29	160	41	14	8	348
REPUBLIC OF IRELAND	132	172	182	32	137	26	681
RUSSIA	104	109	74	19	21	15	342
SCOTLAND	205	176	238	74	165	48	906
SINGAPORE	104	58	26	49	110	-	347
SOUTH AFRICA	627	286	554	110	320	62	1,959
SOUTHERN AFRICA	35	14	20	9	15	3	96
SRI LANKA	298	310	209	71	67	21	976
YUGOSLAVIA	76	51	51	10	24	10	222
ZIMBABWE	17	15	46	19	17	9	123
MIDDLE EAST	171	151	65	28	26	6	447
UNKNOWN	6	5	1	1	3	-	16
ALL OVERSEAS TRAINED	**6,660**	**4,986**	**5,303**	**1,910**	**2,894**	**707**	**22,460(a)**

(a) Note: Includes one doctor for whom State was unknown

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-242

OUTCOME 12: Health Workforce Capacity

Topic: OVERSEAS TRAINED DOCTORS

Written Question on Notice

Senator Adams asked:

Do you have numbers from the past year of overseas doctors who started work in Australia but who subsequently returned to their home country?

Answer:

No information is stored on the Medicare records to indicate when a doctor returned to his or her home country. This information is not required for provider eligibility purposes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-243

OUTCOME 12: Health Workforce Capcity

Topic: OVERSEAS TRAINED DOCTORS

Written Question on Notice

Senator Adams asked:

What ratio is that to the numbers who eventually receive permanent residency or become citizens?

Answer:

This information is not available in Medicare records.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-244

OUTCOME 12: Health Workforce Capacity

Topic: OVERSEAS TRAINED DOCTORS

Written Question on Notice

Senator Adams asked:

a) Do you have information as to the main reasons for peoples returning to their country of birth?
b) Do you have details as to the average stay of overseas doctors?

Answer:

a) Medicare records do not contain information on the main reasons for people returning to their country of birth.

b) Medicare records do not contain information on the average stay of overseas doctors. Some overseas doctors only practise on a salaried basis and do not either render or refer services under Medicare.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 4 June 2009

Question: E09-325

OUTCOME 12: Health Workforce Capacity

Topic: EXPANDING THE SPECIALIST WORKFORCE TO PROVIDE RADIATION ONCOLOGY TREATMENT

Hansard Page: CA 128

Senator Adams asked:

Re: scholarships for these professions announced in the Budget.
Are there any scholarships available for these people, or anything like that, as an incentive to go forward?" …. I would be very interested in that.

Answer:

$1.5 million will be provided to alleviate the shortage that exists in some diagnostic imaging specialties such as sonography, nuclear imaging and radiology. This measure will increase the number of Government supported diagnostic imaging positions by 15 in any one year across the forward estimates period.

In addition, people studying in these areas of health may be eligible and apply for a range of scholarships, many of which are targeted to support rural and remote practice.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-102

OUTCOME 12: Health Workforce Capacity

Topic: MEDICAL WORKFORCE DISTRIBUTION

Written Question on Notice

Senator Nash asked:

a) How will the Department monitor the effect of the changes announced in the budget on workforce distribution and will this monitoring include the effect of the changes on the viability of procedural general practice in rural towns particularly those in Inner Regional RA2 and outer regional RA3 areas?

b) Does the Department expect that larger regional centres such as Bathurst and Hobart will be more attractive for doctors to practise in as a result of the changes?

c) How will these affect smaller rural centres such as Young, Junee and Cootamundra who are competing to attract these doctors to their towns?

Answer:

a) The effects of changes announced will be monitored through the collection of data based on the following performance measures:
   - the number of GPs working in rural and remote areas;
   - retention of current long serving doctors in rural and remote areas;
   - the number of GP Registrars working in rural and remote areas;
   - number of overseas trained doctors, particularly newly recruited overseas trained doctors, seeking to practise in more remote locations to reduce their restriction period under the *Health Insurance Act 1973*;
   - number of Australian trained doctors under 'bonded' arrangements, seeking to practise in rural or more remote rural locations to reduce their return of service obligation period;
   - the number of locums registered under the program;
   - the number of services requested and provided; and
   - the number of services provided to solo GP communities.

b) The Department expects that in some cases larger regional centres such as Bathurst and Hobart will be an attractive proposition for some doctors. However, the Budget package specifically developed and re-designed a number of incentives and return of service obligations to be scaled (or geared) so the greatest benefits are received in the most remote areas. This will be a powerful incentive for doctors who are considering their future location of practice.

An example of the powerful effects of scaling are the current restrictions placed on overseas trained doctors. Under current arrangements, overseas trained doctors are restricted in their access to Medicare benefits under section 19AB of the *Health Insurance Act 1973* – commonly known as the ten year moratorium. Under the new arrangement, to be implemented from 1 July 2010, an overseas trained doctor who chooses to work in large regional centres such as Hobart or Bathurst, will have a period of restrictions of nine years, whereas for more remote areas, such as Bourke or Wilcannia will have a period of restrictions of five years.

c) The introduction of the ASGC-RA classification system will be closely monitored, particularly with regard to changes in doctor numbers in rural areas. It is also important to note that the new Remoteness Area Classification will be updated with each census by the Australian Bureau of Statistics and hence continuously improved over time. Moving to the new system will ensure that rural health programs continue to be classified using the current Australian Standard.

There are plans for an expanded version of ASGC-RA to be implemented in 2011. This will automatically flow through to rural programs to ensure they are assessed using the most appropriate and accurate Australian geographical classification.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June

Question: E09-239

OUTCOME 12: Health Workforce Capacity

Topic: GENERAL PRACTITIONERS

Written Question on Notice

Senator Adams asked:

Can you please explain what the main programs are to improve the long-term national distribution of the medical workforce

Answer:

1. Initiatives designed to attract and recruit students to the medical field:

The Bonded Medical Places (BMP) Scheme and the Medical Rural Bonded Scholarship (MRBS) Scheme

The Bonded Medical Places (BMP) Scheme and the Medical Rural Bonded Scholarship (MRBS) Scheme are part of a long term strategy to provide more doctors in the future for areas where there are medical workforce shortages, including rural areas. These schemes provide medical school places in addition to standard entry medical places at university and have greatly increased the number of medical school places available.

The MRBS Scheme provides 100 additional graduate and undergraduate medical school places, each year, to first-year Australian medical students.

In return for a scholarship while they are studying medicine at university, which is currently worth over $23,222 per year, students agree to work for six continuous years in a rural or remote area of Australia, once they have qualified and attained Fellowship of a specialist college, including general practice.

The BMP Scheme provides over 600 additional graduate and undergraduate medical school places each year to first-year Australian medical students, with 25 per cent of all Commonwealth supported medical school places now allocated under the scheme.

Students who accept a BMP Scheme place agree to work in a district of workforce shortage of their choice for a period of time equal to the length of their medical degree. Districts of workforce shortage are located in outer metropolitan areas of capital cities, as well as regional, rural and remote areas of Australia.

Participants in both schemes are already graduating as doctors, and some MRBS Scheme doctors will be commencing their return of service obligation in rural areas in 2009-10. From 1 July 2010, doctors will be able to reduce the period of return of service obligation, dependent on the location in which they choose to practise. Scaling incentives will be applied where benefits derived will be significantly greater for doctors who choose to live and work in more remote areas.

2. Training initiatives to attract medical graduates to general practice:

Prevocational General Practice Placement Program (PGPPP)

The Prevocational General Practice Placement Program (PGPPP) was announced in November 2003 and since January 2005 has provided up to 280 short term, voluntary, well-supervised placements for junior (prevocational) doctors each year in general practice settings across Australia.

Australian General Practice Training Program

The Australian General Practice Training (AGPT) program is a postgraduate vocational training program for doctors wishing to pursue a career in general practice in Australia. The AGPT program is funded by the Australian Government and delivered by General Practice Education and Training (GPET) through 21 Regional Training Providers (RTP's).

600 new training places are offered each year. 250 of these enroll on the 'rural' pathway, and 350 enroll on the 'general' pathway. Registrars provide services as they train, and so are highly sought after by GP facilities. Registrars provide critical services in many areas of workforce shortages – they provide over 10% of the GP services in rural and remote areas, in comparison with 2.8% of services in urban areas and 5.8% nationally.

3. Incentives and programs to improve distribution of the medical workforce:

General Practice Registrars Rural Incentives Payments Scheme (RRIPS)

The Registrars Rural Incentive Payments Scheme (RRIPS) aims to promote careers in rural medicine and increase the number of doctors in rural and regional areas of Australia in the longer term. To be eligible for RRIPS, registrars must be enrolled in the Australian General Practice Training program or the Remote Vocational Training Scheme. The Registrars will qualify for the RRIPS by completing a period of service in an eligible rural area (RRMA 3-7), or by undertaking an approved special placement. Incentive payments are based on a sliding scale and are linked to the location of the training and length of time spent in that location.

Rural Retention Program

The Rural Retention Program aims to support, through targeted financial incentives, long serving doctors in rural and remote areas experiencing difficulty in retaining GP services. Communities in which these doctors work will benefit through improved access to general practice services and continuity of health care.

From 1 July 2010, under the *Rural Health Workforce Strategy*, RRIPS and RRP will be consolidated as the General Practice Rural Incentive Program (GPRIP) to simplify, improve and streamline the payment and eligibility requirements of rural incentive (retention) grants.

In addition, the new program introduces a rural relocation incentive grant (relocation component) to encourage GPs to practise in rural and remote Australia.

HECS Reimbursement Scheme

The current HECS Reimbursement Scheme reimburses HECS debts of medical students should they choose to train and work in rural and remote communities. Currently debts are reimbursed over a period of five years.

From 1 July 2010, doctors will be able to reduce the period for reimbursement of the cost of their medical studies from five years to two years, dependent on the location in which they choose to practise. The concept of scaling means that benefits derived will be significantly greater for doctors who choose to live and work in more remote areas.

Rural and Remote General Practice Program

The Rural and Remote General Practice Program (RRGPP) funds Rural Workforce Agencies (RWAs) in each state and the Northern Territory to provide a range of activities and support to improve the attraction, recruitment and retention of General Practitioners (GPs) to rural and remote areas. This includes helping communities to recruit GPs, finding appropriate placements for doctors who want to relocate to rural Australia, assisting with the costs of relocation, supporting their families with fitting into a new community and helping GPs to access the necessary infrastructure, support and training.

RWAs are also the central point of contact for GPs and other health professionals interested in practising in rural and remote areas.

Practice Incentive Payments (PIP)

There are three initiatives available through the Practice Incentives Program (PIP) specifically aimed at improving access to services in rural areas.

- the PIP Rural Practice Nurse Incentive aims to encourage general practices in rural and remote areas to employ a practice nurse. Rural practices employing a practice nurse have access to maximum annual funding of $35,000.
- the PIP Procedural GP Payment aims to encourage general practitioners in rural and remote areas to maintain local access to surgical, anesthetics and obstetric services. There are four levels of procedural payments, ranging from $2,000 to $17,000 per annum, that reflect the range and extent of procedural activity provided by each GP.
- PIP practices in rural and remote areas that agree to act as a referral point for people experiencing domestic violence and have an appropriately trained nurse can access payments of up to $4,000 per year.

In addition, a rural loading, ranging from 15 per cent to 50 per cent depending on the remoteness of the practice, is applied to the PIP payments of practices in rural and remote areas. The payment is in recognition of the difficulties of providing care, often with little professional support, in rural and remote areas of Australia.

Rural Other Medical Practitioners (ROMPS) Program

The ROMPs Program provides access to the higher A1 Medicare rebate for services provided by non-vocationally recognised medical practitioners in the following locations and who express an interest in achieving vocational recognition:

- Rural, Remote Metropolitan Area (RRMA) classifications 4-7;
- defined 'areas of consideration'; or
- approved RRMA 3 locations which have severe medical workforce shortages.

After Hours Other Medical Practitioners (AHOMPs) Program

The Program provides access to the A1 Medicare rebate for after hours general practice services, provided through an accredited general practice or an accredited Medical Deputising Service (MDS) by eligible non-vocationally recognised medical practitioners. Eligibility for the Program is not determined by geographical location.

MedicarePlus for Other Medical Practitioners (MOMPs) Program

The Program provides access to the A1 Medicare rebate for services provided in districts of workforce shortage by eligible pre 1996 non-vocationally recognised medical practitioners. Further information on this program can be obtained from Medicare Australia.

More Doctors for Outer Metropolitan Areas – Relocation Incentive Grant (RIG)

The RIG Program is a component of the More Doctors for Outer Metropolitan Areas Measure which commenced in 2003. The RIG Program provides a financial incentive for doctors to relocate to outer metropolitan areas. Doctors must have an unrestricted Medicare provider number and work in an inner metropolitan area for 12 months before applying for the grant or have recently completed GP training.

There are two levels of grant - to set up a new practice in an eligible outer metropolitan area doctors can receive up to $40,000 (plus GST) and up to $30,000 (plus GST) for doctors joining an existing outer metropolitan practice. The grants include commitments to remain for minimum periods.

4. Workforce Support provided to General Practitioners:

Training for Rural and Remote Procedural GPs

The Training for Rural and Remote Procedural GPs Program enables procedural GPs in rural and remote areas to access a grant to attend relevant training, upskilling and skills maintenance activities. The Program has two components:

- a grant for the cost of up to two weeks training, including the cost of locum relief to a maximum of $20,000 per GP per financial year for procedural GPs practising in surgery, anesthetics and/or obstetrics in Rural, Remote and Metropolitan Area (RRMA) 2-7 locations; and
- a grant for the cost of up to three days training, to a maximum of $6,000 per GP per financial year for GPs practising emergency medicine in rural and remote areas (RRMA 3-7) to attend approved skills maintenance and upskilling activities.

From 1 July 2010, the existing TRRPGP Program will be expanded under the *Urban GP Locum Incentive Program*, where in exchange for an agreement to work as a rural locum, non-rural GPs will have access to subsidies. The proposal provides funding to upskill more than 150 urban doctors in exchange for undertaking four-week locum placements in rural and remote communities.

Workforce Support for Rural General Practitioners (WSRGP) Program

The WSRGP Program provides funding to support newly arrived and existing general practice workforce (including registrars and medical students) in rural areas. WSRGP is administered by the 65 Divisions of General Practice with at least 5% of their population living in rural and remote (RRMA 4-7) areas.

Divisions undertake activities that are specific in supporting the workforce needs and well being for GPs. Divisions work in collaboration with stakeholders such as the RWAs to deliver coordinated activities and support for the GP workforce.

National Rural Locum Program

From early 2009-10, under a new National Rural Locum Program, doctors will be eligible to seek locum support through the Rural GP Locum Program, where assistance will be provided to match locums with doctors who need time off to rest or undertake professional development. It is expected that there will be 400 locum placements over four years.

Specialist Obstretricians Locums Scheme

The Specialist Obstetrician Locums Scheme (SOLS) continues to provide locum support to rural specialist obstetricians, generalist obstetricians and anaesthetists including general practitioner (GP) proceduralists.

Rural Locum Relief Program

The Rural Locum Relief Program (RLRP) enables both Australian and OTDs (otherwise not eligible to access Medicare) to undertake rural locum work through a program structure that provides adequate backup and support arrangements in:

- small rural and remote areas and large remote centres (RRMA 4 – 7);
- large regional centres (RRMA 3) with a demonstrated need (eg districts of workforce shortage);
- "Areas of Consideration" (as determined by the Minister for Health and Ageing); and
- all Aboriginal Medical Services (including in RRMA 1 or 2 locations).

The Rural Workforce Agencies in each state and territory are responsible for the administration of the program.

5. Districts of Workforce Shortage (DWS):

DWS is a key mechanism that the Australian Government uses to achieve an equitable distribution of medical services across Australia. A location is deemed to be a DWS if it falls below the national average for the provision of medical services.

Section 19AB of the *Health Insurance Act 1973* (the Act) requires overseas trained doctors (OTDs) wanting to access the Medicare benefits arrangements to work in a DWS. This restriction is for a minimum period of ten years from the date of first medical registration, or from the date the doctor became a permanent resident.

From 1 July 2010, OTDs who are currently subject to ten year restrictions, will be able to reduce their restriction period by up to five years, dependent on the location in which they choose to practice. Benefits derived from the scaling of their restrictions will be significantly greater for doctors who choose to live and work in more remote areas of Australia.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-191

OUTCOME 13: Acute Care

Topic: COMMONWEALTH DENTAL HEALTH PROGRAM

Hansard Page: CA 128

Senator Boyce asked:

(Under the Commonwealth Dental Health Plan) how many dentists would it take to do 166,500 extra consultations?

Answer:

At the time of discussions on implementation of the Commonwealth Dental Health Program at the beginning of 2008, states and territories did not provide comprehensive figures of the additional workforce requirement (dentists, dental therapists, dental prosthetists and/or dental hygienists) to deliver these additional services.

Data provided by the Australian Institute of Health and Welfare's Dental Statistics and Research Unit indicate that dentists provide approximately 2750 visits annually on average. Using this information, the additional visits are estimated to require the equivalent of about 120 additional dentists.

> [Source: *Projected demand and supply for dental visits in Australia: analysis of the impact of changes in key inputs (2008)*]

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-246

OUTCOME 13: Acute Care

Topic: DENTAL SERVICES FOR INDIGENOUS PEOPLE

Written Question on Notice

Senator Adams asked:

The budget papers point to the availability of dental services for Indigenous people in regional and rural areas. What measures does the Government envisage for implementing this program?

Answer:

This program – "Closing the Gap: Indigenous Dental Services in Rural and Regional Areas" – provides $11 million over four years to pilot models for delivering dental services to Indigenous Australians in rural and regional areas, focussing on the use of transportable facilities. Details of service-delivery models, logistical and governance arrangements, and areas in which they are to be rolled out, will be determined during 2009-10.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-289

OUTCOME 13: Acute Care

Topic: COMMONWEALTH DENTAL HEALTH PROGRAM

Written Question on Notice

Senator Boyce asked:

Under the Commonwealth Dental Health Program, the Government will provide priority treatment for people who have chronic conditions relating to their oral health, Indigenous Australians, and preschool children. What are the criteria for determining if a person has chronic conditions relating to oral health?

Answer:

The Commonwealth Dental Health Program (CDHP) was intended to provide priority treatment for people with chronic conditions relating to their oral health.

Priority conditions provisionally agreed with states and territories in 2008 (on the basis that they could have expanded on these groups in accordance with local needs) were:

- Cancer patients – people undergoing chemotherapy or significant immune suppression
- Transplant patients – prior to surgery or requiring immuno-suppression
- Cardiac patients – pre-surgery
- Cardiac patients- at high risk of endocarditis
- People taking bisphosphonates (for cancer, osteoporosis, Pagets)
- People with HIV/AIDS
- People with haemophilia or significant coagulopathy
- Diabetics – insulin-dependant
- People taking xerostomia-inducing drugs/medication

Please note however that as the Senate has prevented closure of the chronic disease dental scheme, the government has not to date been able to implement the CDHP, so this list has no formal status. If the Senate agrees to the closure of the chronic disease dental scheme, enabling the government to implement the CDHP, any arrangements for providing priority access would be renegotiated with states and territories.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-290

OUTCOME 13: Acute Care

Topic: MEDICAL INDEMNITY PROGRAM

Written Question on Notice

Senator Boyce asked:

Can the department explain why is the program's costs increasing when the number of doctors using the scheme is expected to decrease?

Answer:

The government has a number of programs in place which constitute the broader medical indemnity program. Collectively, these programs provide assistance to eligible doctors for the cost of their medical indemnity cover and help to ensure ongoing stability in the broader medical indemnity market. The programs are: the Incurred But Not Reported (IBNR) Scheme; the High Cost Claims Scheme (HCCS); the Premium Support Scheme (PSS), the Exceptional Claims Scheme (ECS) and the Run-Off Cover Scheme (ROCS).

Currently, the scheme with the highest annual expenditure component of the overall program cost is the PSS. The cost of the PSS varies according to a range of factors, including: the number of eligible doctors participating in the scheme; the impact on premiums due to competition in the local medical indemnity insurance industry, and the cost of re-insurance from overseas financial markets. As premiums rise, more doctors will become eligible. As premiums fall, some doctors will cease to be eligible

In relation to the IBNR Scheme, ROCS and the ECS, these schemes respond to claims as they arise and are not impacted by the number of doctors participating in the Premium Support Scheme. As eligible claims emerge, mature and become payable, expenditure in these programs will tend to rise over time, but will ultimately assume a reduced annual expenditure pattern in the longer term as the number of potentially eligible claims continues to reduce.

There are a number of legislated reporting requirements that are associated with these schemes and the department is charged with ensuring that these are met to the required standard and within the required timeframe.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-192

OUTCOME 13: Acute Care

Topic: COMMONWEALTH DENTAL HEALTH PROGRAM

Hansard Page: CA 128

Senator Boyce asked:

Could we have a list or a breakdown of the one million and the targets for each of those years state by state.

Answer:

The Commonwealth did not specify annual targets for individual jurisdictions under the Commonwealth Dental Health Program. Overall three-year targets were calculated in 2008 for states and territories on the basis of their proportion of Commonwealth health card holders. These were as follows:

State	No. additional visits
NSW	327,200
Vic	258,000
Qld	187,000
WA	82,000
SA	85,600
Tas	30,000
ACT	15,000
NT	10,610

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-001

OUTCOME 13: Acute Care

Topic: ORGAN TRANSPLANTATION

Written Question on Notice

Senator Ryan asked:

How many available organs are not utilised for transplantation procedures each year due to administrative or logistical problems (e.g. timely delivery) across Australia and respectively in:

a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?

Answer:

The Australia and New Zealand Organ Donation (ANZOD) Registry records and reports data on the number of available donated organs not retrieved by the donor state for transplantation, and the reason for non-retrieval, by each jurisdiction each year.

Reasons for non-retrieval related to 'administrative' and 'logistical' problems include 'logistics', 'team not available', 'surgeon unavailable', 'distance', 'transport not available', 'coordinator not available', 'laboratory not available', 'time constraints', and 'theatre constraints'.

The number and type of available organs not retrieved in each donor state for reasons of a logistical or administrative nature for the last year is given in the following table.

2008

	VIC	NSW	WA	QLD	TAS	SA	NT	ACT	TOTAL
Kidney	-	-	-	-	-	-	-	-	**0**
Liver	-	1	-	-	-	-	-	-	**1**
Heart	1	-	1	-	-	-	-	-	**2**
Lung	-	-	-	-	-	1	-	-	**1**
Pancreas*	4	6	4	6	-	2	-	-	**22**

Source: ANZOD Registry Report 2009

* Each year, the vast majority of organs not utilised are pancreas. This is primarily because only New South Wales and Victoria operate a pancreas transplant program and there is a relative 'over supply' with respect to demand.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-002

OUTCOME 13: Acute Care

Topic: ORGAN AND TISSUE DONATION – WAITING TIME DEATHS

Written Question on Notice

Senator Ryan asked:

How many people die each year while waiting for an organ transplant across Australia and respectively in:

a) Victoria?
b) New South Wales?
c) Queensland?
d) South Australia?
e) Western Australia?
f) Tasmania?
g) ACT?
h) NT?

Answer:

There are no reliable data on the number of people who die each year while waiting for an organ transplant. Presently, national data on organ and tissue donation and transplantation is collected by the Australia and New Zealand Organ Donation Registry, which publishes an annual report. The current report does not include data on deaths while waiting for a transplant.

The collection of reliable information of this type is problematic for a number of reasons.

First, while the number of people waiting for an organ transplant at any given time can be estimated by reference to organ transplant waiting lists, patients move on and off waiting lists as their clinical circumstances change. Some patients may have their transplant deferred due to an improvement in their condition. Some move off waiting lists if their condition deteriorates and they become too sick for the transplant procedure. This may be due either to the failing organ or for other reasons. Patients may return to the waiting list if their condition improves or stabilises.

Secondly, patients in need of an organ transplant who die when not on the organ transplant waiting list may not have their transplant status recorded.

Thirdly, the cause of death of someone waiting for an organ transplant, whether on the waiting list or not, may not be directly attributable to their need for a transplant.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-003

OUTCOME 13: Acute Care

Topic: ORGAN TRANSPLANTATION

Written Question on Notice

Senator Ryan asked:

a) Is there any available evidence of Australian patients going overseas for organ transplantation?
b) If so, where is such evidence sourced from?
c) What does this evidence comprise of?
d) Does the AIHW collect or maintain data relating to this?

Answer:

a – d)

There are no systematically collected data on Australian patients going overseas for organ transplantation.

An article published in the *Medical Journal of Australia* in 2005[14] reports the outcomes of 16 Australian patients who travelled overseas between 1990 and 2004 for the purpose of receiving a commercial kidney transplant. The reported case series is the result of a survey of renal units at the Prince of Wales Hospital, Royal North Shore Hospital and St George Hospital, Sydney, and the Illawarra Regional Hospital, Wollongong, New South Wales.

Patients sought kidney transplants in China (7), India (4), Lebanon (2), Iraq (1), the Philippines (1), and Eastern Europe (1). The article concluded that patients who received overseas commercial transplants were more likely to develop serious infections and had worse patient and transplanted kidney survival than are achieved in patients transplanted in Australia.

The Australian Institute of Health and Welfare does not collect or maintain any data on Australians travelling overseas for organ transplantation.

14 Kennedy SE, Shen Y, Charlesworth JA, et al. Outcome of overseas commercial kidney transplantation: an Australian perspective. *MJA* 2005; 182 (5):224-227.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-004

OUTCOME 13: Acute Care

Topic: ORGAN TRANSPLANTATION OVERSEAS

Written Question on Notice

Senator Ryan asked:

a) Is the Department aware of any Australians who have died overseas during or as a result of an organ transplant being performed outside Australia?

b) Is the Department aware of Australians, having undergone organ donation overseas, experiencing adverse health outcomes on or following return to Australia?

Answer:

a – b)

There are no systematically collected data on Australians who have died or who have experienced adverse health outcomes as a result of undergoing organ transplantation overseas.

There is a case series published in the scientific literature that highlights some areas of concern about overseas commercial kidney transplantation involving Australians.

The article, published in the *Medical Journal of Australia* in 2005[15], reports the outcomes of 16 Australian patients who travelled overseas between 1990 and 2004 for the purpose of receiving a commercial kidney transplant. Transplants were sought in China (7), India (4), Lebanon (2), Iraq (1), Philippines (1), and Eastern Europe (1).

The article concluded that patients who received overseas commercial transplants were more likely to develop serious infections and had worse patient and transplanted kidney survival than are achieved in patients transplanted in Australia.

Of the 16 cases reported, two patients contracted Hepatitis B virus infection, which led to death, three patients returned to Australia with serious cytomegalovirus infections requiring hospitalisation, and one patient returned with a severe fungal infection requiring the subsequent removal of the transplanted kidney.

15 Kennedy SE, Shen Y, Charlesworth JA, et al. Outcome of overseas commercial kidney transplantation: an Australian perspective. *MJA* 2005; 182 (5):224-227.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-005

OUTCOME 13: Acute Care

Topic: ORGANS SENT OVERSEAS

Written Question on Notice

Senator Ryan asked:

a) Have any organs sourced from within Australia been sent overseas?
b) If so, what are the criteria for such a transfer?
c) If so, can the Department provide a list of the location of the recipient for all Australian organs sent overseas in the last five years?
d) Can organs be sent overseas if an eligible and suitable patient exists in Australia?

Answer:

a – d)

Some livers donated in Australia are sent to New Zealand for transplantation. Australia does not supply any organs to any other country.

The allocation and distribution of donated organs in Australia is guided by protocols developed by the Transplantation Society of Australia and New Zealand (TSANZ). TSANZ protocols guide the allocation of donated livers, pancreas, hearts, lungs, kidneys and corneas.

The 'liver protocol' includes New Zealand as a participating State and livers donated in Australia are sent to New Zealand in accordance with the protocol. Similarly, livers donated in New Zealand are available for transplantation in Australia in accordance with the protocol.

Hearts, lungs, livers, kidneys and pancreas donated in New Zealand and not required for transplantation in New Zealand are offered to Australian transplant centres in accordance with the relevant protocol.

The exchange of donated organs for transplantation between Australia and New Zealand over the last five years is shown in the following tables:

Organs sent from Australia to New Zealand

	2004	2005	2006	2007	2008
Liver	7	6	12	4	9

Source: ANZOD Registry Reports 2005, 2006, 2007, 2008 and 2009

Organs sent from New Zealand to Australia

	2004	2005	2006	2007	2008
Kidney	1	4	-	-	-
Liver	7	5	8	8	2
Heart	2	3	1	3	2
Lung	4	5	5	8	4

Source: ANZOD Registry Reports 2005, 2006, 2007, 2008 and 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-006

OUTCOME 13: Acute Care

Topic: ORGAN AND TISSUE DONATION

Written Question on Notice

Senator Ryan asked:

a) Are non-residents in Australia eligible for donated organs and transplant procedures?
b) If so, the Department have records of how many such procedures have been performed?
c) Can the Department outline the number of non-residents in Australia who have received donated organs over the last five years?

Answer:

a – b)

Non-residents are eligible for donated organs and transplant procedures in Australia if they meet the medical criteria, are accepted onto a transplant centre waiting list and that transplant centre is offered a suitably matched organ for a non-resident.

The allocation and distribution of donated organs to transplant centres in Australia is guided by protocols developed by the Transplantation Society of Australia and New Zealand (TSANZ). TSANZ protocols guide the allocation of donated livers, pancreas, hearts, lungs, kidneys and corneas.

c) There is no data that indicates the number of transplant procedures provided to non-residents.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-047

OUTCOME 13: Acute Care

Topic: METHICILLIN – RESISTANT STAPHYLOCOCCUS AUREUS (MRSA)

Written Question on Notice

Senator Ryan asked:

In each state and territory, which five hospitals have had the highest number of infections, and how many infections have occurred in each hospital?

Answer:

MRSA infection rates are currently not systematically reported at the national, state or hospital level. Some states publish this data (South Australian and Western Australian) but not at hospital level as part of the new National Healthcare Agreement.

Coding changes introduced from 1 July 2008 will allow separations in which an MRSA infection originated to be easily identified. Performance Indicator 26b - *Staphylococcus aureus (including MRSA) bacteraemia in acute care hospitals* will allow rates of hospital acquired MRSA infection to be consistently identified and reported nationally as part of the new National Healthcare Agreement.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-079

OUTCOME 13: Acute Care

Topic: HEALTH CARE AGREEMENTS

Written Question on Notice

Senator Siewert asked:

I understand that the new health care agreements are being finalised with a renewed focus on monitoring and measurement of performance. Do health consumers have any input into inter-government agreements, including measures of successful health service delivery?

Answer:

In February 2008, the Australian Institute of Health and Welfare (AIHW) was commissioned by the Australian Health Ministers' Conference to prepare a set of performance indicators to support the development of the new National Healthcare Agreement (NHA). The indicator development process included extensive consultation with stakeholders, including consumer representatives. The indicator set published by the AIHW in June 2008 provided the foundation for the health performance indicators that were ultimately agreed by COAG in November 2008.

The indicator development process also assisted the development of the outcomes, progress measures and outputs in the NHA. Stakeholder views expressed to the National Health and Hospitals Reform Commission on health system reform generally, including those of health consumer representatives, were also relevant background to the development of the NHA.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-118

OUTCOME 13: Acute Care

Topic: ORGAN DONATION

Hansard Page: CA 140

Senator Boyce asked:

On that basis then, could you also give us the figures - and you might need to take this on notice, Ms Murphy - on how many positions you will be funding, with a breakdown for each state, please.

Answer:

Through funding agreements with each state and territory Government, the Australian Organ and Tissue Donation and Transplantation Authority is funding the appointment of a total of 136.45 full-time equivalent staff based in the states and territories as follows:

	SMD	**HMD**	**Nurses**	**OTDAs**	Total
NSW	1	10	19	8	38
WA	1	3	4.45	5.5	13.95
TAS	0.5	0.5	2.5	*	3.5
QLD	1	4	10.5	8	23.5
VIC	1	8.4	15.1	8	32.5
SA	1	2	5	5.5	13.5
ACT	0.5	0.5	1	3.75	5.75
NT	0.5	0.5	1	3.75	5.75
	6.5	28.9	58.55	42.5	136.45

SMD – State Medical Director
HMD – Hospital Medical Director
OTDAs – Organ & Tissue Donation Agencies

* Tasmania and South Australia operate a shared service

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-119

OUTCOME 13: Acute Care

Topic: ORGAN DONATION

Hansard Page: CA 140

Senator Siewert asked:

How much funding has the Commonwealth contributed [towards the Transplant Games]?

Answer:

Under the current 2006-2010 funding arrangements with Transplant Australia the Commonwealth has contributed the following amounts to support the Transplant Games:

$274,192 (GST Exclusive) 2006-07
$943,000 (GST Exclusive) 2007-08
$347,273 (GST Exclusive) 2008-09

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-188

OUTCOME 13: Acute Care

Topic: PERFORMANCE INDICATORS

Hansard Page: CA 122

Senator Boyce asked:

How many working groups are working on this (performance indicators) at the moment?

Answer:

The Australian Health Ministers' Conference (AHMC) and the officials' committees supporting it are primarily responsible for the development and ongoing improvement of the health performance indicator set. Under the direction of these committees, jurisdictions have been assigned responsibility for particular indicators, and have established working groups for those indicators where significant data development or supply issues arise. The Department of Health and Ageing has established two working groups on patient experience and aged care indicators, respectively.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-189

OUTCOME 13: Acute Care

Topic: HOSPITAL REPORTING

Hansard Page: CA 125

Senator Boyce asked:

The data provided through that program (public hospitals and information) will be analysed and published in reports by AIHW et cetera. Analysed by whom?

Answer:

The data provided through the public hospitals and information program will be collected and analysed by the following bodies:

- The Australian Institute of Health and Welfare (AIHW) will collect and analyse hospital data and the results will be published annually in the *Australian Hospital Statistics* report as well as various other AIHW publications.
- The Department of Health and Ageing will publish public hospital data in *The state of our public hospitals report.* Public hospital data will also be analysed by the department for program development and other policy purposes.
- The Productivity Commission provides public hospital data analysis through its annual Report on Government Services (RoGS).
- The RoGS Steering Committee will prepare a report on National Healthcare Agreement performance for the COAG Reform Council.
- The COAG Reform Council will assess public hospital data to assess whether performance payments under National Partnership Agreements can be made.
- The states and territories also provide data to the department as well as publishing their own reports. This information is used to improve health service delivery.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-195

OUTCOME 13: Acute Care

Topic: INTERGOVERNMENTAL AGREEMENTS

Hansard Page: CA 119

Senator Boyce asked:

What payments are automatic and what are performance based - in a lovely table?

Answer:

Information is presented for all funding agreements that provide funding in 2008-09 at Attachment A.

Attachment A

Program	Payment methodology
Long Stay Older Patients Program	The Long Stay Older Patients Program Memorandum of Understanding indicates as follows. o Payment of 50% of the agreed funding amount for a financial year will be made by the Australian Government on submission by the state or territory (not later than 30 September) of a satisfactory acquittal of funds received for the previous financial year. o Payment of 50% of the agreed funding amount for a financial year will be made by the Commonwealth 30 days after submission by the state or territory of an up-to-date implementation plan covering the current financial year that has been accepted by the Commonwealth as consistent with the parameters determined by COAG for the initiative.
Elective Surgery Waiting List Reduction Plan – Stage Two	o ACT and NT - Full payment made 7 days after execution of funding agreement. o NSW- Payment of 30% of total available funding under the program made 7 days after execution of funding agreement. Payment of 3.4% of total available funding under the program made on 1 August 2008. Payment of 66.6% of total available funding under the program made on 1 July 2009 following receipt and acceptance of the initial progress report. o VIC – Payment of 68.5% of total available funding under the program made 7 days after execution of funding agreement. Payment of 31.5% of total available funding under the program made on 1 July 2009 following receipt and acceptance of the initial progress report. o QLD – Payment of 50% of total available funding under the program made 7 days after execution of funding agreement. Payment of 50% of total available funding under the program made on 1 July 2009 following receipt and acceptance of the initial progress report. o WA - Payment of 32.4% of total available funding under the program made 7 days after execution of funding agreement. Payment of 30% of total available funding under the program made on 1 August 2008. Payment of 37.6% of total available funding under the program made on 1 July 2009 following receipt and acceptance of the initial progress report. o SA – Payment of 38.3% of total available funding under the program made 7 days after execution of funding agreement. Payment of 61.7% of total available funding under the program made on 1 July 2009 following receipt and acceptance of the initial progress report. o TAS - Payment of 67.7% of total available funding under the program made 7 days after execution of funding agreement. Payment of 32.3% of total available funding under the program made on 1 August 2008.

Elective Surgery Waiting List Reduction Plan – Stage One	o NSW, VIC, WA, SA, TAS, NT – Payment of 33.3% of total available funding under the program made 7 days after signing. Payment of 66.7% of total available funding under the program made on 1 July 2008 following receipt and acceptance of second quarterly reporting on 30 April 2008. o QLD - Payment of 100% of total available funding under the program made on 1 July 2008 following receipt and acceptance of second quarterly reporting on 30 April 2008. o WA - Payment of 62.5% of total available funding under the program made 7 days after signing. Payment of 37.5% of total available funding under the program made on 1 July 2008 following receipt and acceptance of second quarterly reporting on 30 April 2008. o ACT - Payment of 30% of total available funding under the program made 7 days after signing. Payment of 70% of total available funding under the program made on 1 July 2008 following receipt and acceptance of second quarterly reporting on 30 April 2008.
Bacchus Marsh Hospital Capital Upgrades	o Payment of 50% of total available funding under the program made following receipt of a correctly rendered invoice by 30 June 2008. o Payment of 37.5% of total available funding under the program made upon receipt and acceptance of the first Progress Report – due 30 September 2008. o Payment of 12.5% of total available funding under the program made upon receipt and acceptance of the second Progress Report – due 31 March 2009.
North Lakes Health Precinct Renal Project	o Payment of 28.5% of total available funding under the program made following receipt of a correctly rendered invoice by 30 June 2008. o Payment of 35.7% of total available funding under the program made upon receipt and acceptance of the first Progress Report – due 30 September 2008. o Payment of 35.7% of total available funding under the program made upon receipt and acceptance of the second Progress Report – due 31 March 2009.
Tasmanian Patient Transport and Accommodation Initiative	o Full annual payment for 2008-09 made 7 days after execution of funding agreement. o Full annual payment for 2009-10 made after receipt and acceptance of a project plan. o Full annual payment for future years made after receipt and acceptance of a progress report.

National Partnership Agreement on Hospital and Health Workforce Reform	o The Taking Pressure off Public Hospitals component made $750 million available for emergency departments. o States and territories provided the Commonwealth implementation plans outlining their approach to reform, which was approved by Minister Roxon and payment was made in June 2009. o States and territories must report on a suite of agreed performance indicators and service provision benchmarks annually, which will be independently assessed by the COAG Reform Council. o The Subacute Care reform made $500 million available to deliver improved subacute care services, including rehabilitation, palliative care, geriatric evaluation and management, and psychogeriatric care within the community. o States and territories provided the Commonwealth implementation plans outlining their approach to reform, which was approved by Minister Roxon and payment was made in June 2009. o States and territories must report on a suit of agreed performance indicators and service provision benchmarks annually, which will be independently assessed by the COAG Reform Council. o The Activity Based Funding (ABF) component payments are automatic. The 2008/2009 payments, which totaled $36.5 million, were processed by Treasury on 9 June 2009. o At total of $153.567 million has been committed to the ABF project - $133.410 million for the states, with the Commonwealth retaining the remainder to develop and implement ABF data management infrastructure at the national level. o Future payments to the states and territories are: $41.4 million in 2011-12, and $55.52 million in 2012-13.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-283

OUTCOME 13: Acute Care

Topic: HEALTH AND HOSPITAL FUNDING

Written Question on Notice

Senator Boyce asked:

As part of COAG's $64 billion boost to health and hospital funding, the National Healthcare Agreement provides funding of $60 billion over five years, an increase in total of $22 billion over the previous set of agreements. The success of these areas will be measured by a "comprehensive range of performance indicators for the health sector that will provide a basis for regular public reporting of the hospital and wider health sector through the COAG reform council".
a) Can the Department provide a list of what these performance indicators will be?
b) What role will the Department take in measuring the performance data?

Answer:

a) The Council of Australian Government (COAG) has agreed to 70 health performance indicators, which are listed at Attachment A.

b) The performance of all governments against the health performance indicators will be monitored and assessed by the COAG Reform Council, which will report publicly on an annual basis. The Council's first report on health performance indicators is expected in March 2010. This report will establish benchmarks against which progress in reform and improvements in service delivery can be measured.

ATTACHMENT A

COAG HEALTH PERFORMANCE INDICATORS

1 Proportion of babies born with low birth weight
2 Incidence of sexually transmitted infections and blood-borne viruses
3 Prevalence of end-stage renal disease
4 Incidence of mostly avoidable cancers (lung, bowel, breast, cervical and skin)
5 Proportion of persons obese
6 Proportion of adults who are daily smokers
7 Proportion of adults at risk of long-term harm from alcohol
8 Proportion of men reporting unprotected anal intercourse with casual male partners
9 Immunisation rates for vaccines in the national schedule
10 Cancer screening rates (breast)
11 Cancer screening rates (cervical)
12 Cancer screening rates (bowel)
13 Proportion of children with 4th year developmental health check
14 Waiting times for GPs
15 Waiting times for public dentistry
16 People deferring recommended treatment due to financial barriers
17 Proportion of diabetics with HbA1c below 7%
18 Life expectancy (including the gap between Indigenous and non-Indigenous)
19 Infant/young child mortality rate (including the gap between Indigenous and non-Indigenous)
20 Potentially avoidable deaths
21 Treated prevalence rates for mental illness
22 Selected potentially preventable hospitalisations
23 Selected potentially avoidable GP-type presentations to emergency departments
24 Number of GP-type services funded through MBS
25 Specialist services
26 Dental services
27 Optometry services
28 Public sector community mental health services
29 Private mental health services
30 Proportion of diabetics with GP annual cycle of care
31 Proportion of asthmatics with a written asthma plan
32 Proportion of people with mental illness with GP care plans
33 Number of women with at least one antenatal visit in the first trimester of pregnancy
34 Waiting times for elective surgery
35 Waiting times for emergency department care
36 Waiting times for admission following emergency department care
37 Waiting times for public and private radiotherapy and orthopaedic specialists
38 Adverse drug events
39 Staphylococcus aureus (including MRSA) bacteraemia in acute care hospitals
40 Pressure ulcers in care settings
41 Fall resulting in patient harm in care settings

42 Intentional self-harm in hospitals
43 Unplanned/unexpected readmissions within 28 days of surgical admissions
44 Survival of people diagnosed with cancer
45 Overnight separations
46 Outpatient occasions of service
47 Non-acute care separations
48 Differential access to hospital procedures
49 Residential and community aged care services per 1,000 population aged 70+ years
50 Staphylococcus aureus (including MRSA) bacteraemia in residential aged care
51 Pressure ulcers in care settings
52 Fall resulting in patient harm in care settings
53 Number of older people receiving aged care services by type
54 Number of aged care assessments conducted
55 Number of younger people with disabilities using residential, CACP and EACH aged care services
56 Number of people 65+ receiving sub-acute and rehabilitation services
57 Number hospital patient days used by those eligible and waiting for residential aged care
58 Nationally comparative information that indicates levels of patient satisfaction around key aspects of care they received
59 Age-standardised mortality
60 Access to services by type of service compared to need
61 Teenage birth rate
62 Hospitalisation for injury and poisoning
63 Children's hearing loss
64 Indigenous Australians in the health workforce
65 Net growth in health workforce
66 Public health program expenditure as a proportion of total health expenditure
67 Capital expenditure as a proportion of total health and aged care expenditure
68 Proportion of health expenditure spent on health research and development
69 Cost per case mix-adjusted separation for both acute and non acute care episodes
70 Number of accredited and filled clinical training positions

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-284

OUTCOME 13: Acute Care

Topic: OH&S IN HOSPITALS

Written Question on Notice

Senator Boyce asked:

a) Does the department collect data with regard to occupational health and safety incidents in Australia's hospitals?
b) Can the department make that data available for the previous three years?

Answer:

a) No, this information would be held by the relevant states and territories.
b) Not applicable.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-285

OUTCOME 13: Acute Care

Topic: HOSPITALS

Written Question on Notice

Senator Boyce asked:

The Government has committed to fund $153.6 million to move towards a nationally consistent system of activity based funding for public hospital services, which will enhance accountability in the delivery of health services by capturing consistent and detailed information on hospital activity.

a) Can the department outline the existing problems with capturing data and what kind of hospital details will be captured that were not previously?
b) Does the plan have mechanisms in place to compare data collection with that collected by private hospitals?

Answer:

a) Implementation of nationally consistent activity based funding requires the development of patient level classification systems and costing methodologies for the full range of hospital care types, namely acute care, emergency department care, subacute care, outpatient services and hospital sponsored community health services.

   Current data capture for acute care is well developed due to longstanding patient level application of the International Classification of Diseases (whose most recent version is ICD 10 AM), the Australian Refined Diagnostic Related Group (AR DRG) system which groups ICD records for cost homogeneity, and the National Cost Hospital Data Collection (NHCDC). Some minor amendments to the AR DRG and the NHCDC will be required to make them suitable for activity based funding and alignment of versions will be necessary for national consistency. The National Partnership Agreement on Hospital and Health Workforce Reform (Schedule A: Activity Based Funding) provides a broad framework for the initiative and requires these modifications by the end of the 2009-10 financial year.

   Data capture in relation to patient characteristics and episode cost is less well advanced in the other care types. Schedule A requires developmental work for these other care types to be complete by the end of 2012-13.

b) The National Partnership Agreement (NPA) on Hospital and Health Workforce Reform states that the Commonwealth will have responsibility, in collaboration with states and territories, for engaging with the private sector to improve comparability of performance between the public and private sectors.

Implementation of activity based funding is being managed by the National Partnership Agreement on Hospital and Health Workforce Reform Implementation Steering Committee, whose membership comprises senior public sector officials. Discussions with public and private sector representatives are currently underway to establish mechanisms to help ensure alignment of data collection between the sectors.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-286

OUTCOME 13: Acute Care

Topic: SUB-ACUTE CARE

Written Question on Notice

Senator Boyce asked:

The Government will provide $500 million to the states and territories in 2008-09 to deliver improved subacute care services, including rehabilitation, palliative care, geriatric evaluation and management, and psych-geriatric care within the community and hospital settings.

a) Can the department provide the numbers of how many Australians in each state and territory use these services currently?
b) How many are expected to use them after the improvements?

Answer:

a) The Department cannot provide the number of Australians in each state and territory who use subacute care services within hospital and community settings as data is not currently collected in this form. However data is available on admitted hospital separations and admitted hospital patient days for subacute care in Australia.

   There is no equivalent national data available for subacute care in community (including non-admitted hospital) settings. Through the National Partnership Agreement the Commonwealth, states and territories have agreed to improve data collection and reporting arrangements for subacute care services. Implementation plans developed by states and territories under the National Partnership Agreement include data on subacute care services, and the implementation plans are expected to be made publicly available on the Ministerial Council for Federal Financial Relations website http://www.federalfinancialrelations.gov.au

   Data on admitted hospital separations and hospital patient days are published annually by the Australian Institute of Health and Welfare (AIHW). Data from the most recent AIHW report is presented below.

2007/08 **Separations** by subacute care type for public hospitals

Care Type	NSW	Vic	QLD	WA	SA	Tas	ACT	NT	Total
Rehabilitation	25,954	13,400	16,853	8,496	6,884	1,141	2,249	469	75,446
Palliative Care	8,273	5,128	4,266	1,392	1,388	268	572	311	21,598
Geriatric Evaluation and Management	1,806	11,017	537	617	201	24	540	71	14,813
Psycho-geriatric Care	1,007	2,016	500	656	259	29	21	6	4,494

Source: *Australian Hospital Statistics 2007-08*, AIHW, Table 7.11, pp171

2007/08 **Patient days** by subacute care type for public hospitals

Care Type	NSW	Vic	QLD	WA	SA	Tas	ACT	NT	Total
Rehabilitation	525,879	299,293	254,832	160,923	125,503	28,855	29,602	4,644	1,429,531
Palliative Care	103,239	76,206	39,312	13,058	18,676	3,523	7,095	3,281	264,390
Geriatric Evaluation and Management	16,591	297,287	8,113	5,713	2,031	231	6,801	1,581	338,348
Psycho-geriatric Care	64,763	62,651	11,698	31,725	40,771	50	467	149	212,274

Source: *Australian Hospital Statistics 2007-08*, AIHW, Table 7.12, pp172

b) Access to subacute care services is expected to increase as a result of subacute care reforms under the National Partnership Agreement, and improved estimates. The Commonwealth has provided $500 million for states and territories to expand their subacute care services by five per cent annually, or twenty per cent over the four year period of the National Partnership Agreement, and all states and territories have provided implementation plans detailing how they propose to reach these targets. Plans are expected to be made publicly available on the Ministerial Council for Federal Financial Relations website http://www.federalfinancialrelations.gov.au

Through the National Partnership Agreement the Commonwealth, states and territories have agreed to improve data collection and reporting arrangements for subacute care, including development of a nationally consistent method for measuring growth in the provision of subacute care services by December 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-287

OUTCOME 13: Acute Care

Topic: HOSPITAL CLASSIFICATION SYSTEM

Written Question on Notice

Senator Boyce asked:

The Government will provide $39.6 million for the department to improve hospital related classifications systems, costing methodologies and data for performance measurements and accountability purposes.

a) Which areas are the states and territories continuing to use non-uniform methods of measuring performance?
b) Will the patient classifications systems be standard across both private and public hospitals?

Answer:

a) The areas which states and territories are not using non-uniform methods of measuring performance are in emergency department care, subacute care, outpatient services and hospital sponsored community health services.

b) Yes, the program objective is to have a standard patient classifications system for both sectors.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-288

OUTCOME 13: Acute Care

Topic: ELECTIVE SURGERY

Written Question on Notice

Senator Boyce asked:

There was a target in 2008 for elective surgery waiting lists to clear more than 25,000 additional patients who had been waiting longer than clinically recommended for their surgery. The states and territories exceeded this target by 64 per cent, providing surgery for more than 41,000 additional patients. Can the department break this performance down into the number of patients that each state and territory treated?

Answer:

The table below provides a breakdown of the number of additional procedures each state and territory agreed to undertake in 2008, and the number actually provided.

State/Territory	Additional procedures to be undertaken in 2008	Additional procedures undertaken in 2008
NSW	8,743	12,153
Vic	5,908	13,478
Qld	4,000	5,928
WA	2,720	3,727
SA	2,262	3,196
Tas	895	1,606
ACT	250	858
NT	500	638
NATIONAL	**25,278**	**41,584**

These figures were provided in the state and territory reports collated in the national *Elective Surgery Waiting List Reduction Plan December 2008 Quarter Report* published in March 2009 on the Department's website at *http://www.health.gov.au/internet/main/publishing.nsf/Content/elective-surgery-progress.*

The results were also provided graphically in the *State of Our Public Hospitals June 2009* report published on 30 June 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-291

OUTCOME 13: Acute Care

Topic: NATIONAL BLOOD ARRANGEMENTS

Written Question on Notice

Senator Boyce asked:

The Government will provide funding of $1.5 million over 2009-10 and 2010-11 to support an administrative review of the national blood arrangements.

a) Can the Agency outline the terms of the review?
b) When will the review be completed and has the review reached any conclusions as to where increased costs are coming from?

Answer:

a) The Terms of Reference for the $1.5 million review process of the national blood arrangements have not yet been finalised.

b) The administrative review has not yet commenced, but is expected to be completed early in 2010.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-10, 3 & 4 June 2009

Question: E09-292

OUTCOME 13: Acute Care

Topic: TRANSPORTING AND SUPPLYING BLOOD

Written Question on Notice

Senator Boyce asked:

The National Blood Authority's (NBA) Deputy General Manager, Andrew Mead, has stated that the costs of transporting and supplying blood are increasing by 8 per cent each year.

a) Is the NBA finding it difficult to operate without receiving an additional 8 percent of funding each year across the board, or is it specific operations of the NBA which require funding?

b) Have any services been cut to the increase in costs without a comparable increase in funding? If no, are any services likely to be cut?

Answer:

a) The figure quoted in the Sydney Morning Herald (SMH) dated 21 May 2009 relates to the proportion of administered funding for the purchase and supply of blood and blood products. The cost of blood and blood products are funded by all governments under the National Blood Agreement. The Commonwealth contribution is appropriated through a special appropriation that provides an ongoing annual estimate and is managed to take into account demand driven increases such as that mentioned in the SMH article. These increases do not impact on the National Blood Authority's (NBA) departmental funding.

b) No. Refer to a).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-190

OUTCOME 13: Acute Care

Topic: DENTAL INDICATORS

Hansard Page: CA 126-127

Senator Williams asked:

In relation to public dental health, how do you monitor the success of those programs run by the states?

Answer:

At its meeting on 29 November 2008, Council of Australian Government agreed to a new National Healthcare Agreement and an associated set of health performance indicators, including one counting the number of dental services. This indicator is expected to cover both public and private dental services.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-123

OUTCOME 13: Acute Care

Topic: NSW CHARGING PRIVATE HOSPITALS FOR BLOOD AND BLOOD PRODUCTS

Hansard Page: CA 131

Senator Cormann asked:

Can you please outline for me on notice whether and how the Commonwealth would have legislative powers to prevent NSW from proceeding with this tax on blood, should it be required?

Answer:

A Review has been agreed of the governance arrangements under the National Blood Agreement, and the question of individual jurisdictions charging for blood and blood products, amongst other issues, will be considered as part of the review.

Australian Government

Department of Health and Ageing

Senator Claire Moore
Chair
Senate Community Affairs Committee
Parliament House
Canberra ACT 2600

Dear Senator Moore

Correction to evidence given at hearing of 3 June 2009

I am writing to correct an error in the evidence which I gave at the Committee's hearing on 3 June 2009.

The relevant transcript appears at page CA131, commencing with a question from Senator Cormann:

Senator CORMANN – But have you sought advice? And is there the possibility that the Commonwealth could take legal action to prevent New South Wales from proceeding if that were required…

After a brief exchange between Ms Halton and Senator Cormann, I responded:

Mr Reid – The question, as I understand it, is: does the Commonwealth have the power to legislate to stop New South Wales imposing charges for blood? That is not a question we have sought advice about. It is likely that the Commonwealth has legislative power to legislate to do that, but –

Senator Cormann – Sorry, say that again. Is it likely?

Mr Reid – It is likely that the Commonwealth has legislative power to legislate to do that, but it is not a subject we have sought advice from Attorney-General's on.

On 16 June 2009, it was brought to my attention that an officer of the Department of Health and Ageing had in December 2008 sought advice from the Australian Government Solicitor in relation to the Commonwealth's power to amend the *National Blood Authority Act 2003* and the *Private Health Insurance Act 1983* to override State legislation. In the course of its advice, the Australian Government Solicitor provided advice about the Commonwealth's legislative power to prevent persons from requiring payments to be made by entities to which blood or blood products are supplied.

Departmental Executive MDP 84 GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 5822 Fax: (02) 6285 1994 ABN 83 605 426 759

I apologise for inadvertently misleading the Committee on this point.

Yours sincerely
Chris Reid
General Counsel
7 July 2009

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-117

OUTCOME 13: Acute Care

Topic: ORGAN DONATION

Hansard Page: CA 138

Senator Williams asked:

If you signed your driver's licence in New South Wales to donate organs and it was challenged in court or the family had a disagreement, it was not valid. Is it still the situation? Does anyone know?

Answer:

It is the practice in Australia, and many overseas countries, to respect the wishes of the next of kin if they object to organ donation taking place. A valid consent instrument is essentially a legal record of a person's consent or objection to have organs and tissue removed from their body for the purposes of donation. The mere existence of a "yes" consent instrument does not guarantee that a donation will proceed as there is no legal imperative that a "yes" consent must be acted upon (ie. there is no provision in any Human Tissue Act in Australia that requires a medical specialist to remove organs on the basis of a "yes" consent instrument irrespective of whether the consent is registered with the NSW Roads and Traffic Authority, the Australian Organ Donor Register or any other form of written consent).

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-187

OUTCOME 13: Acute Care

Topic: HOSPITALS

Hansard Page: CA 120

Senator Boyce asked:

Would it be possible to get a baseline table of all the current public hospitals by state, and their locations.

Answer: There are currently 768 declared public hospitals in Australia. This information is sourced from the department's internal data holdings and is a list of those hospitals declared under Section 121-5(6) of the Private Health Insurance Act 2007, as at 6 July 2009.

The names and locations of these hospitals are as follows in Attachment A.

NSW

Hospital	Suburb/Town	Postcode
Albury Base Hospital	ALBURY	2640
Armidale Hospital	ARMIDALE	2350
Auburn Hospital	AUBURN	2144
Ballina District Hospital	BALLINA	2478
Balmain Hospital	BALMAIN	2041
Balranald Health Service	BALRANALD	2715
Bankstown-Lidcombe Hospital	BANKSTOWN	2200
Baradine Multi Purpose Service	BARADINE	2396
Barham Hospital	BARHAM	2732
Barraba Multi Purpose Service	BARRABA	2347
Batemans Bay Hospital	BATEMANS BAY	2536
Bathurst Base Hospital	BATHURST	2795
Batlow Hospital	BATLOW	2730
Bega District Hospital	BEGA	2550
Bellinger River District Hospital	BELLINGEN	2454
Belmont Hospital	BELMONT	2280
Berrigan Hospital	BERRIGAN	2628
Bingara Multipurpose Service	BINGARA	2404
Blacktown Hospital	BLACKTOWN	2148
Blayney Multipurpose Service	BLAYNEY	2799
Bloomfield Hospital	ORANGE	2800
Blue Mountains District ANZAC Memorial Hospital	KATOOMBA	2780
Boggabri Health Service	BOGGABRI	2382
Bombala Hospital	BOMBALA	2630
Bonalbo Health Service	BONALBO	2469
Boorowa Hospital	BOOROWA	2586
Bourke Multi Purpose Service	BOURKE	2840
Bourke Street Health Service Goulburn	GOULBURN	2580
Bowral and District Hospital	BOWRAL	2576
Braeside Hospital	PRAIRIEWOOD	2176
Braidwood District Hospital	BRAIDWOOD	2622
Brewarrina Multi Purpose Service	BREWARRINA	2839
Broken Hill Health Service	BROKEN HILL	2880
Bulahdelah Community Hospital	BULAHDELAH	2423
Bulli Hospital	BULLI	2516
Byron District Hospital	BYRON BAY	2481
Calvary Health Care Sydney Ltd	KOGARAH	2217
Calvary Mater Newcastle	WARATAH	2298
Camden Hospital	CAMDEN	2570
Campbelltown Hospital	CAMPBELLTOWN	2560
Canowindra Hospital	CANOWINDRA	2804
Canterbury Hospital	CAMPSIE	2194
Casino and District Memorial Hospital	CASINO	2470
Cessnock District Hospital	CESSNOCK	2325
Cobar Hospital	COBAR	2835

Hospital	Suburb/Town	Postcode
Coffs Harbour Health Campus	COFFS HARBOUR	2450
Coledale Hospital	COLEDALE	2515
Collarenebri Health Service	COLLARENEBRI	2833
Concord Repatriation General Hospital	CONCORD	2139
Condobolin Hospital	CONDOBOLIN	2877
Coolah Multi Purpose Service	COOLAH	2843
Coolamon Hospital	COOLAMON	2701
Cooma District Hospital	COOMA	2630
Coonabarabran Hospital	COONABARABRAN	2357
Coonamble Health Service	COONAMBLE	2829
Cootamundra District Hospital	COOTAMUNDRA	2590
Corowa Hospital	COROWA	2646
Cowra Hospital	COWRA	2794
Crookwell Hospital	CROOKWELL	2583
Culcairn Hospital	CULCAIRN	2660
Cumberland Hospital	WESTMEAD	2145
David Berry Hospital	BERRY	2535
Delegate District Hospital	DELEGATE	2633
Deniliquin Hospital	DENILIQUIN	2710
Denman Multi Purpose Service	DENMAN	2328
Dorrigo Multi Purpose Service	DORRIGO	2453
Dubbo Base Hospital	DUBBO	2830
Dunedoo War Memorial Health Service	DUNEDOO	2844
Dungog Community Hospital	DUNGOG	2420
Emmaville Mulit Purpose Service	EMMAVILLE	2371
Eugowra Hospital	EUGOWRA	2806
Fairfield Hospital	PRAIRIEWOOD	2176
Finley Hospital	FINLEY	2713
Forbes District Hospital	FORBES	2871
Gilgandra Multi Purpose Service	GILGANDRA	2827
Glen Innes Hospital	GLEN INNES	2370
Gloucester Soldiers Memorial Hospital	GLOUCESTER	2422
Goodooga Hospital	GOODOOGA	2831
Gosford Hospital	GOSFORD	2250
Goulburn Base Hospital	GOULBURN	2580
Governor Phillip Hospital	PENRITH	2751
Gower Wilson Memorial Hospital	LORD HOWE ISLAND	2398
Grafton Base Hospital	GRAFTON	2460
Greenwich Hospital	GREENWICH	2065
Grenfell Health Service	GRENFELL	2810
Griffith Base Hospital	GRIFFITH	2680
Gulargambone Multi Purpose Service	GULARGAMBONE	2828
Gulgong Health Service	GULGONG	2850
Gundagai Hospital	GUNDAGAI	2722
Gunnedah District Health Service	GUNNEDAH	2380
Guyra Multi Purpose Service	GUYRA	2365

Hospital	Suburb/Town	Postcode
Harden Hospital	HARDEN	2587
Hay District Hospital	HAY	2711
Henty Hospital	HENTY	2658
Hillston Hospital	HENTY	2675
Holbrook Hospital	HOLBROOK	2644
Hornsby Ku-ring-gai Hospital	HORNSBY	2077
Inverell District Hospital	INVERELL	2360
Ivanhoe Health Service	IVANHOE	2878
James Fletcher	NEWCASTLE	2300
Jerilderie Hospital	JERILDERIE	2716
John Hunter Children's Hospital	NEW LAMBTON HEIGHTS	2305
John Hunter Hospital	NEW LAMBTON HEIGHTS	2305
Junee Hospital	JUNEE	2663
Karitane	CARRAMAR	2163
Kempsey District Hospital	KEMPSEY	2440
Kenmore Hospital	KENMORE	2580
Kiama Hospital	KIAMA	2533
Kurri Kurri District Hospital	KURRI KURRI	2327
Kyogle Memorial Multi Purpose Service	KYOGLE	2474
Lake Cargelligo Multi Purpose Service	LAKE CARGELLIGO	2672
Leeton Hospital	LEETON	2705
Lightning Ridge Multipurpose Health Service	LIGHTNING RIDGE	2834
Lismore Base Hospital	LISMORE	2480
Lismore Base Hospital - Riverlands Drug & Alcohol Service	LISMORE	2480
Lithgow Integrated Health Service	LITHGOW	2790
Liverpool Hospital	LIVERPOOL	2170
Lockhart & District Hospital	LOCKHART	2656
Long Jetty Hospital	KILLARNEY VALE	2261
Lottie Stewart Hospital	DUNDAS	2117
Lourdes Hospital & Community Health Services	DUBBO	2830
Macksville Health Campus	MACKSVILLE	2447
Maclean District Hospital	MACLEAN	2463
Manilla Health Service	MANILLA	2346
Manly Hospital	MANLY	2095
Manning Rural Referral Hospital	TAREE	2430
Menindee Health Service	MENINDEE	2879
Mercy Care Centre	YOUNG	2594
Mercy Health Service	ALBURY	2640
Merriwa Community Hospital	MERRIWA	2329
Milton Ulladulla Hospital	MILTON	2538
Molong Hospital	MOLONG	2866
Mona Vale Hospital	MONA VALE	2103
Moree District Health Service	MOREE	2400
Moruya District Hospital	MORUYA	2537

Hospital	Suburb/Town	Postcode
Mount Druitt Hospital	MOUNT DRUITT	2770
Mudgee Health Service	MUDGEE	2850
Mullumbimby & District War Memorial Hospital	MULLUMBIMBY	2482
Murwillumbah District Hospital	MURWILLUMBAH	2484
Muswellbrook District Health Service	MUSWELLBROOK	2333
Narrabri District Health Service	NARRABRI	2391
Narrandera Hospital	NARRANDERA	2700
Narromine Health Service	NARROMINE	2821
Nepean Hospital	KINGSWOOD	2750
Neringah Hospital	WAHROONGA	2076
Nimbin Multi Purpose Service	NIMBIN	2480
Nyngan Health Service	NYNGAN	2825
Oberon Multi Purpose Service	OBERON	2787
Orange Base Hospital	ORANGE	2800
Pambula District Hospital	PAMBULA	2549
Parkes Health Service	PARKES	2870
Peak Hill Hospital	PEAK HILL	2869
Port Kembla Hospital	WARRAWONG	2502
Port Macquarie Base Hospital	PORT MACQUARIE	2444
Portland Tabulam Health Centre	PORTLAND	2847
Prince Albert Memorial Tenterfield	TENTERFIELD	2372
Prince of Wales Hospital	RANDWICK	2031
Queanbeyan Hospital	QUEANBEYAN	2620
Quirindi Community Hospital	QUIRINDI	2343
Rankin Park Centre	NEW LAMBTON HEIGHTS	2305
Royal Hospital for Women	RANDWICK	2031
Royal North Shore Hospital	ST LEONARDS	2065
Royal Prince Alfred Hospital	CAMPERDOWN	2050
Royal Rehabilitation Centre Sydney	RYDE	2112
Ryde Hospital	EASTWOOD	2122
Rylstone Health Service	RYLSTONE	2849
Sacred Heart	DARLINGHURST	2010
Scone District Hospital	SCONE	2337
Shellharbour Hospital	SHELLHARBOUR	2529
Shoalhaven District Memorial Hospital	NOWRA	2541
Singleton District Hospital	SINGLETON	2330
Springwood Hospital	SPRINGWOOD	2777
St George Hospital (NSW)	KOGARAH	2217
St Joseph's Hospital	AUBURN	2144
St Vincent's Hospital (Darlinghurst)	DARLINGHURST	2010
St Vincent's Hospital (Lismore)	LISMORE	2480
Sydney Children's Hospital	RANDWICK	2031
Sydney Dental Hospital	SURRY HILLS	2010
Sydney Hospital and Sydney Eye Hospital	SYDNEY	2000
Tamworth Hospital	TAMWORTH	2340

Hospital	Suburb/Town	Postcode
Temora Hospital	TEMORA	2666
The Campbell Hospital, Coraki	CORAKI	2471
The Children's Hospital at Westmead	WESTMEAD	2145
The Forensic Hospital	MALABAR	2036
The Maitland Hospital	MAITLAND	2320
The Sutherland Hospital	CARINGBAH	2228
The Tweed Hospital	TWEED HEADS	2485
Tibooburra Health Service	TIBOOBURRA	2880
Tingha Multipurpose Service	TINGHA	2369
Tocumwal Hospital	TOCUMWAL	2714
Tomaree Community Hospital	NELSON BAY	2315
Tottenham Hospital	TOTTENHAM	2873
Trangie Multi Purpose Health Service	TRANGIE	2823
Tresillian Family Care Centre - Belmore	BELMORE	2192
Tresillian Family Care Centre - Willoughby	WILLOUGHBY	2068
Tresillian Family Care Centre - Wollstonecraft	WOLLSTONECRAFT	2065
Trundle Multi Purpose Service	TRUNDLE	2875
Tullamore Multi Purpose Health Service	TULLAMORE	2874
Tumbarumba District Hospital	TUMBARUMBA	2653
Tumut Hospital	TUMUT	2720
Urana Hospital	URANA	2645
Urbenville Multi Purpose Service	URBENVILLE	2475
Wagga Wagga Base Hospital	WAGGA WAGGA	2650
Walcha Multipurpose Service	WALCHA	2354
Walgett Health Service	WALGETT	2832
War Memorial Hospital, Waverley	WAVERLEY	2024
Warialda Multipurpose Service	WARIALDA	2402
Warren Multi Purpose Health Service	WARREN	2824
Wauchope District Memorial Hospital	WAUCHOPE	2446
Wee Waa Health Service	WEE WAA	2388
Wellington Hospital	WELLINGTON	2820
Wentworth District Hospital and Health Service	WENTWORTH	2648
Werris Creek Community Hospital	WERRIS CREEK	2341
West Wyalong Hospital	WEST WYALONG	2671
Westmead Hospital	WESTMEAD	2145
White Cliffs Health Service	WHITE CLIFFS	2836
Wilcannia Health Service	WILCANNIA	2836
Wilson Memorial Community Hospital	MURRURRUNDI	2338
Wingham Community Hospital	WINGHAM	2428
Wollongong Hospital	WOLLONGONG	2500
Woy Woy Hospital	WOY WOY	2256

Hospital	Suburb/Town	Postcode
Wyong Hospital	KANWAL	2259
Yass District Hospital	YASS	2582
Young District Hospital	YOUNG	2594

VIC

Hospital	Suburb/Town	Postcode
Alexandra District Hospital	ALEXANDRA	3714
Alpine Health (Bright)	BRIGHT	3741
Alpine Health (Mount Beauty)	MT BEAUTY	3699
Alpine Health (Myrtleford)	MYRTLEFORD	3736
Angliss Hospital	UPPER FERNTREE GULLY	3156
Austin Health - Austin Hospital	HEIDELBERG	3084
Austin Health - Heidelberg Repatriation Hospital	HEIDELBERG	3084
Bairnsdale Regional Health Service	BAIRNSDALE	3875
Ballarat Health Services (Base Hospital)	BALLARAT CENTRAL	3350
Ballarat Health Services (Queen Elizabeth Centre)	BALLARAT	3350
Barwon Health - Ashley Manor Campus	BELMONT	3216
Barwon Health - Geelong Hospital Campus	GEELONG	3220
Barwon Health - John Robb House	BELMONT	3216
Barwon Health - McKellar Centre Campus	NORTH GEELONG	3219
Barwon Health - Newcomb Renal Unit Campus	NEWCOMB	3219
Barwon Health - South Geelong Renal Unit Campus	SOUTH GEELONG	3220
Bass Coast Regional Health	WONTHAGGI	3995
Beaufort & Skipton Health Services - Beaufort Campus	BEAUFORT	3373
Beaufort & Skipton Health Services - Skipton Campus	SKIPTON	3361
Beechworth Health Service	BEECHWORTH	3747
Benalla and District Memorial Hospital	BENALLA	3672
Bendigo Health Care Group (Anne Caudle)	BENDIGO	3550
Bendigo Health Care Group (Bendigo Hospital)	BENDIGO	3550
Boort District Health	BOORT	3537
Box Hill Hospital	BOX HILL	3128
Broadmeadows Health Service	BROADMEADOWS	3074
Bundoora Extended Care Centre	BUNDOORA	3083
Calvary Health Care Bethlehem Ltd	CAULFIELD	3162
Caritas Christi Hospice	KEW	3101
Casey Hospital	BERWICK	3806

Hospital	Suburb/Town	Postcode
Casterton Memorial Hospital	CASTERTON	3311
Caulfield General Medical Centre	CAULFIELD	3162
Central Gippsland Health Service (Maffra)	MAFFRA	3860
Central Gippsland Health Service (Sale)	SALE	3850
Cobram District Hospital	COBRAM	3644
Cohuna District Hospital	COHUNA	3568
Colac Area Health	COLAC	3250
Craigieburn Health Service	CRAIGIEBURN	3064
Cranbourne Integrated Care Centre	CRANBOURNE	3977
Dandenong Hospital	DANDENONG	3175
Dental Health Services Victoria	CARLTON	3053
Djerriwarrh Health Service	BACCHUS MARSH	3340
Dunmunkle Health Services	RUPANYUP	3388
East Grampians Health Service	ARARAT	3377
East Grampians Health Service (Willaura)	WILLAURA	3379
East Wimmera Health Service (Birchip)	BIRCHIP	3483
East Wimmera Health Service (Charlton)	CHARLTON	3525
East Wimmera Health Service (Donald)	DONALD	3480
East Wimmera Health Service (St Arnaud)	ST ARNAUD	3478
East Wimmera Health Service (Wycheproof)	WYCHEPROOF	3527
Echuca Regional Health	ECHUCA	3564
Edenhope and District Memorial Hospital	EDENHOPE	3318
Frankston Hospital	FRANKSTON	3199
Frankston Rehabilitation Unit	FRANKSTON	3199
Gippsland Southern Health Service - Korumburra Campus	KORUMBURRA	3950
Gippsland Southern Health Service - Leongatha Campus	LEONGATHA	3953
Goulburn Valley Health (Cambermere Campus)	SHEPPARTON	3630
Goulburn Valley Health (Shepparton Campus)	SHEPPARTON	3630
Goulburn Valley Health (Tatura Campus)	TATURA	3616
Goulburn Valley Health (Waranga Campus)	RUSHWORTH	3612
Healesville & District Hospital	HEALESVILLE	3777
Hepburn Health Service (Creswick)	CRESWICK	3363
Hepburn Health Service (Daylesford)	DAYLESFORD	3460
Hesse Rural Health Service	WINCHELSEA	3241

Hospital	Suburb/Town	Postcode
Heywood Rural Health	HEYWOOD	3304
Inglewood and District Health Service	INGLEWOOD	3517
Kerang District Health	KERANG	3579
Kilmore and District Hospital	KILMORE	3764
Kingston Centre	HEATHERTON	3192
Kooweerup Regional Health Service	KOOWEERUP	3981
Kyabram & District Health Services	KYABRAM	3620
Kyneton District Health Service	KYNETON	3444
Latrobe Regional Hospital	TRARALGON	3844
Lorne Community Hospital	LORNE	3232
Maldon Hospital	MALDON	3463
Mallee Track Health and Community Service	OUYEN	3490
Manangatang and District Hospital	MANANGATANG	3546
Mansfield District Hospital	MANSFIELD	3722
Maroondah Hospital	RINGWOOD EAST	3135
Maryborough District Health Service (Dunolly)	DUNOLLY	3472
Maryborough District Health Service (Maryborough)	MARYBOROUGH	3465
McIvor Health and Community Services	HEATHCOTE	3523
Melton Health - Djerriwarrh Health Services	MELTON WEST	3337
Mercy Hospital for Women	HEIDELBERG	3084
Monash Medical Centre, Clayton Campus	CLAYTON	3168
Monash Medical Centre, Moorabbin Campus	BENTLEIGH EAST	3165
Mount Eliza Rehabilitation, Aged and Palliative Care	MOUNT ELIZA	3930
Moyne Health Services	PORT FAIRY	3284
Mt Alexander Hospital	CASTLEMAINE	3450
Nathalia District Hospital	NATHALIA	3638
Northeast Health Wangaratta	WANGARATTA	3677
Numurkah District Health Service	NUMURKAH	3636
O'Connell Family Centre	CANTERBURY	3126
Omeo District Health	OMEO	3898
Orbost Regional Health	ORBOST	3888
Otway Health and Community Services	APOLLO BAY	3233
Panch Health Service	PRESTON	3072
Peter James Centre	FOREST HILL	3131
Peter MacCallum Cancer Institute	EAST MELBOURNE	3002
Portland District Health	PORTLAND	3305
Robinvale District Health Services	NYAH WEST	3549

Hospital	Suburb/Town	Postcode
Rochester and Elmore District Health Service	ROCHESTER	3561
Rosebud Hospital	ROSEBUD	3939
Royal Melbourne Hospital - City Campus	PARKVILLE	3052
Royal Melbourne Hospital - Royal Park Campus	PARKVILLE	3052
Royal Talbot Rehabilitation Centre	KEW	3101
Rural Northwest Health - Hopetoun Campus	HOPETOUN	3396
Rural Northwest Health - Warracknabeal Campus	WARRACKNABEAL	3393
Sandringham and District Memorial Hospital	SANDRINGHAM	3191
Seymour District Memorial Hospital	SEYMOUR	3660
South Gippsland Hospital	FOSTER	3960
South West Healthcare, Camperdown Campus	CAMPERDOWN	3260
Southwest Health Care - Warrnambool and District Base Hospital	WARRNAMBOOL	3280
St George's Health Service	KEW	3101
St Vincent's Hospital (Melbourne) Ltd	FITZROY	3065
Stawell Regional Health	STAWELL	3380
Sunshine Hospital	ST ALBANS	3021
Swan Hill District Health	SWAN HILL	3585
Tallangatta Health Service	TALLANGATTA	3700
Terang & Mortlake Health Service	TERANG	3264
The Alfred	MELBOURNE	3004
The Mornington Centre	MORNINGTON	3931
The Northern Hospital	EPPING	3076
The Queen Elizabeth Centre	NOBLE PARK	3174
The Royal Children's Hospital	PARKVILLE	3052
The Royal Victorian Eye and Ear Hospital	EAST MELBOURNE	3002
The Royal Women's Hospital	PARKVILLE	3052
Thomas Embling Hospital	FAIRFIELD	3078
Timboon & District Healthcare Service	TIMBOON	3268
Tweddle Child and Family Health Service	FOOTSCRAY	3011
Upper Murray Health and Community Services	CORRYONG	3707
Wantirna Health	WANTIRNA	3152
Werribee Mercy Hospital	WERRIBEE	3030
Werribee Mercy Mental Health Program	WERRIBEE	3030
West Gippsland Healthcare Group	WARRAGUL	3820

Hospital	Suburb/Town	Postcode
West Wimmera Health Service (Jeparit)	JEPARIT	3423
West Wimmera Health Service (Kaniva)	KANIVA	3419
West Wimmera Health Service (Nhill)	NHILL	3418
West Wimmera Health Service (Rainbow)	RAINBOW	3424
Western District Health Service - Coleraine and District Health Service Campus	COLERAINE	3315
Western District Health Service - Hamilton Base Hospital Campus	HAMILTON	3300
Western District Health Service - Penshurst and District Health Service Campus	PENSHURST	3289
Western Hospital	FOOTSCRAY	3011
Williamstown Hospital	WILLIAMSTOWN	3016
Wimmera Health Care Group (Dimboola)	DIMBOOLA	3414
Wimmera Health Care Group (Horsham)	HORSHAM	3400
Wodonga Regional Health Service	WODONGA	3690
Yarra Ranges Health	LILYDALE	3140
Yarram & District Health Service	YARRAM	3971
Yarrawonga District Health Service	YARRAWONGA	3730
Yea and District Memorial Hospital	YEA	3717

QLD

Hospital	Suburb/Town	Postcode
Alpha Hospital	ALPHA	4724
Aramac Hospital	ARAMAC	4726
Atherton Hospital	ATHERTON	4883
Augathella Hospital	AUGATHELLA	4477
Aurukun Primary Health Care Centre	AURUKUN	4871
Ayr Hospital	AYR	4807
Babinda Hospital	BABINDA	4861
Badu Island Primary Health Care Centre	BADU ISLAND	4875
Baillie Henderson Hospital	TOOWOOMBA	4350
Bamaga Hospital	BAMAGA	4876
Bamaga Primary Health Care Centre	BAMAGA	4876
Baralaba Hospital	BARALABA	4702
Barcaldine Hospital	BARCALDINE	4725
Beaudesert Hospital	BEAUDESERT	4285
Biggenden Hospital	BIGGENDEN	4621
Biloela Hospital	BILOELA	4715

Hospital	Suburb/Town	Postcode
Blackall Hospital	BLACKALL	4472
Blackwater Hospital	BLACKWATER	4717
Boigu Island Primary Health Care Centre	BOIGU ISLAND	4875
Bollon Bush Nursing Service	BOLLON	4488
Boonah Hospital	BOONAH	4310
Boulia Primary Health Centre	BOULIA	4829
Bowen Hospital	BOWEN	4805
Boyne Valley Nursing Post	MANY PEAKS	4680
Brisbane Dental Hospital	BRISBANE	4000
Bundaberg Hospital	BUNDABERG	4670
Burketown Health Clinic	BURKETOWN	4830
Caboolture Hospital	CABOOLTURE	4510
Cairns Base Hospital	CAIRNS	4870
Caloundra Hospital	CALOUNDRA	4551
Camooweal Hospital	CAMOOWEAL	4828
Capella Outpatients Clinic	CAPELLA	4702
Carrara Health Centre	CARRARA	4211
Charleville Hospital	CHARLEVILLE	4470
Charters Towers Hospital	CHARTERS TOWERS	4820
Charters Towers Rehabilitation Unit	CHARTERS TOWERS	4820
Cherbourg Hospital	CHERBOURG	4605
Child & Youth Mental Health Services	TOWNSVILLE	4817
Childers Hospital	CHILDERS	4660
Children's Oral Health Service	HERSTON	4029
Chillagoe Hospital	CHILLAGOE	4871
Chinchilla Hospital	CHINCHILLA	4413
Clermont Hospital	CLERMONT	4721
Cloncurry Hospital	CLONCURRY	4824
Coconut Island Primary Health Care Centre	COCONUT ISLAND	4875
Coen Primary Health Care Centre	COEN	4871
Collinsville Hospital	COLLINSVILLE	4804
Cooktown Hospital	COOKTOWN	4895
Cracow Outpatients Clinic	CRACOW	4719
Croydon Hospital	CROYDON	4871
Cunnamulla Hospital	CUNNAMULLA	4490
Dajarra Health Clinic	DAJARRA	4825
Dalby Hospital Health Service	DALBY	4405
Darnley Island Primary Health Care Centre	DARNLEY ISLAND	4875
Dauan Island Primary Health Care Centre	DAUAN ISLAND	4875
Dimbulah Hospital	DIMBULAH	4872
Dirranbandi Hospital	DIRRANBANDI	4486
Doomadgee Hospital	DOOMADGEE	4830
Duaringa Outpatients Clinic	DUARINGA	4702
Dysart Hospital	DYSART	4745
Eidsvold Hospital	EIDSVOLD	4627
Ellen Barron Family Centre	CHERMSIDE	4032
Emerald Hospital	EMERALD	4720

Hospital	Suburb/Town	Postcode
Erub Island Primary Health Centre	ERUB ISLAND	4875
Esk Hospital	ESK	4312
Forsayth Hospital	FORSAYTH	4871
Gatton Hospital	GATTON	4343
Gayndah Hospital	GAYNDAH	4625
Gemfields Outpatients Clinic	SAPPHIRE	4702
Georgetown Hospital	GEORGETOWN	4871
Gin Gin Hospital	GIN GIN	4671
Gladstone Hospital	GLADSTONE	4680
Glenmorgan Outpatients Clinic	GLENMORGAN	4423
Gold Coast Hospital	SOUTHPORT	4215
Goondiwindi Hospital	GOONDIWINDI	4413
Gordonvale Hospital	GORDONVALE	4865
Gympie Hospital	GYMPIE	4570
Herberton Hospital	HERBERTON	4872
Hervey Bay Hospital	PIALBA	4655
Home Hill Hospital	HOME HILL	4806
Hopevale Primary Health Care Centre	HOPEVALE	4871
Horn Island Primary Health Care Centre	HORN ISLAND	4875
Hughenden Hospital	HUGHENDEN	4821
Ingham Hospital	INGHAM	4850
Inglewood Multipurpose Health Service	INGLEWOOD	4387
Injinoo Primary Health Care Centre	INJINOO	4876
Injune Hospital	INJUNE	4454
Innisfail Hospital	INNISFAIL	4860
Ipswich Hospital	IPSWICH	4305
Isisford Primary Health Centre	ISISFORD	4731
Jandowae Hospital	JANDOWAE	4410
Joyce Palmer Health Service	PALM ISLAND	4816
Julia Creek Hospital	JULIA CREEK	4823
Jundah Primary Health Centre	JUNDAH	4736
Karumba Health Clinic	KARUMBA	4891
Kilcoy Hospital	KILCOY	4515
Kingaroy Hospital & Community Health Centre	KINGAROY	4610
Kirwan Acquired Brain Injury Unit	KIRWAN	4817
Kirwan Rehabilitation Unit	KIRWAN	4817
Kowanyama Primary Health Care Centre	KOWANYAMA	4871
Kubin Primary Health Care Centre	MOA ISLAND	4875
Laidley Hospital	LAIDLEY	4341
Laura Primary Health Care Centre	LAURA	4871
Lockhart River Primary Health Care Centre	LOCKHART RIVER	4871
Logan Hospital	MEADOWBROOK	4131
Longreach Hospital	LONGREACH	4730

Hospital	Suburb/Town	Postcode
Mabuiag Island Primary Health Care Centre	MABUIAG ISLAND	4875
Mackay Base Hospital	MACKAY	4740
Magnetic Island Health Service Centre	MAGNETIC ISLAND	4819
Malanda Health Centre	MALANDA	4885
Maleny Hospital	MALENY	4552
Mapoon Primary Health Care Centre	MAPOON	4874
Mareeba Hospital	MAREEBA	4880
Marie Rose Centre, Dunwich	NORTH STRADBROKE ISLAND	4183
Maryborough Hospital	MARYBOROUGH	4650
Meandarra Outpatients Clinic	MEANDARRA	4422
Miles Hospital	MILES	4415
Millaa Millaa Health Centre	MILLAA MILLAA	4886
Millmerran Hospital	MILLMERRAN	4357
Mitchell Hospital	MITCHELL	4465
Monto Hospital	MONTO	4630
Moonie Outpatients Clinic	MOONIE	4406
Moranbah Hospital	MORANBAH	4744
Mornington Island Hospital	MORNINGTON ISLAND	4871
Morven Outpatients Clinic	MORVEN	4468
Mossman Hospital (Douglas Shire Multi Purpose Health Service)	MOSSMAN	4873
Mount Garnet Health Centre	MOUNT GARNET	4872
Mount Isa Base Hospital	MOUNT ISA	4825
Mount Morgan Hospital	MOUNT MORGAN	4714
Mount Perry Health Centre	MOUNT PERRY	4671
Moura Hospital	MOURA	4718
Mundubbera Hospital	MUNDUBBERA	4626
Mungindi Hospital	MUNGINDI	2406
Murgon Hospital	MURGON	4605
Murray Island Primary Health Care Centre	MURRAY ISLAND	4875
Muttaburra Primary Health Centre	MUTTABURRA	4732
Nambour General Hospital	NAMBOUR	4560
Nanango Hospital	NANANGO	4615
Napranum Primary Health Care Centre	WEIPA	4874
New Mapoon Primary Health Care Centre	MAPOON	4874
Normanton Hospital	NORMANTON	4890
Oakey Hospital	OAKEY	4401
Pormpuraaw Primary Health Care Centre	PORMPURAAW	4871
Princess Alexandra Hospital	WOOLLOONGABBA	4102
Proserpine Hospital	PROSERPINE	4800
Proston Outpatients Clinic	PROSTON	4613

Hospital	Suburb/Town	Postcode
Queen Elizabeth II Jubilee Hospital	COOPERS PLAINS	4108
Quilpie Hospital	QUILPIE	4480
Ravenshoe Health Centre	RAVENSHOE	4888
Redcliffe Hospital	REDCLIFFE	4020
Redland Hospital	CLEVELAND	4163
Richmond Hospital	RICHMOND	4822
Rockhampton Base Hospital	ROCKHAMPTON	4700
Roma Hospital	ROMA	4455
Royal Brisbane & Women's Hospital (Inc Rosemount)	HERSTON	4029
Royal Children's Hospital	HERSTON	4029
Saibai Island Primary Health Care Centre	SAIBAI ISLAND	4876
Sarina Hospital	SARINA	4737
Seisia Primary Health Care Centre	SEISIA	4876
South Brisbane Dental Hospital	WOOLLOONGABBA	4102
Springsure Hospital	SPRINGSURE	4722
St George Hospital (QLD)	ST GEORGE	4487
St Paul's Primary Health Care Centre	ST PAUL'S MOA ISLAND	4875
Stanthorpe Hospital	STANTHORPE	4380
Stephen Island Primary Health Care Centre	STEPHEN ISLAND	4875
Surat Hospital	SURAT	4417
Tambo Primary Health Centre	TAMBO	4478
Tara Hospital	TARA	4421
Taroom Hospital	TAROOM	4420
Texas Hospital Multipurpose Health Service	TEXAS	4385
Thargomindah Hospital	THARGOMINDAH	4492
The Institute of Child and Youth Mental Health	SPRING HILL	4000
The Park - Centre for Mental Health	WACOL	4076
The Prince Charles Hospital	CHERMSIDE	4032
The Townsville Hospital	DOUGLAS	4814
Theodore Hospital	THEODORE	4719
Thursday Island Hospital	THURSDAY ISLAND	4875
Thursday Island Primary Health Care Centre	THURSDAY ISLAND	4875
Toowoomba Hospital	TOOWOOMBA	4350
Tully Hospital	TULLY	4854
Umagico Primary Health Care Centre	UMAGICO	4876
Wallumbilla Hospital	WALLUMBILLA	4428
Wandoan Outpatients Clinic	WANDOAN	4419
Warraber Island Primary Health Care Centre	WARRABER ISLAND	4875
Warwick Hospital	WARWICK	4370
Weipa Hospital	WEIPA	4874
Windorah Clinic	WINDORAH	4481
Winton Hospital	WINTON	4735

Hospital	Suburb/Town	Postcode
Wondai Hospital	WONDAI	4606
Woorabinda Hospital	WOORABINDA	4702
Wujal Wujal Primary Health Care Centre	WUJAL WUJAL	4895
Wynnum Hospital	LOTA	4179
Yam Island Primary Health Care Centre	YAM ISLAND	4875
Yaraka Clinic Outpost of Blackall Hospital	YARAKA	4702
Yarrabah Hospital	YARRABAH	4871
Yeppoon Hospital	YEPPOON	4703
Yorke Island Primary Health Care Centre	YORKE ISLAND	4875

SA

Hospital	Suburb/Town	Postcode
Angaston District Hospital	ANGASTON	5353
Balaklava Soldiers Memorial District Hospital	BALAKLAVA	5461
Booleroo Centre District Hospital and Health Service	BOOLEROO CENTRE	5482
Bordertown Memorial Hospital	BORDERTOWN	5268
Burra Hospital	BURRA	5417
Ceduna District Health Services	CEDUNA	5690
Clare Hospital	CLARE	5453
Cleve District and Aged Care	CLEVE	5640
Coober Pedy Hospital and Health Services	COOBER PEDY	5723
Cowell Community Health and Aged Care	COWELL	5602
Crystal Brook & District Hospital	CRYSTAL BROOK	5523
Cummins & District Memorial Hospital	CUMMINS	5631
Elliston Hospital	ELLISTON	5670
Eudunda Hospital	EUDUNDA	5374
Flinders Medical Centre	BEDFORD PARK	5042
Gawler Health Service	GAWLER EAST	5118
Glenside Campus	GLENSIDE	5065
Gumeracha District Soldiers Memorial Hospital	GUMERACHA	5233
Hawker Memorial Hospital	HAWKER	5434
Jamestown Hospital and Health Services	JAMESTOWN	5491
Kangaroo Island Health Service	KINGSCOTE	5223
Kapunda Hospital	KAPUNDA	5373
Karoonda and District Soldiers' Memorial Hospital	KAROONDA	5307
Kimba District Health and Aged Care	KIMBA	5641
Kingston Soldiers' Memorial Hospital	KINGSTON	5275

Hospital	Suburb/Town	Postcode
Lameroo District Health Services	LAMEROO	5302
Laura and District Hospital	LAURA	5480
Leigh Creek Health Services	LEIGH CREEK	5731
Loxton Hospital Complex	LOXTON	5333
Lyell McEwin Hospital	ELIZABETH VALE	5112
Maitland Hospital	MAITLAND	5573
Meningie and Districts Memorial Hospital and Health Services	MENINGIE	5264
Millicent and District Hospital and Health Services	MILLICENT	5280
Modbury Hospital	MODBURY	5092
Mount Barker District Soldiers Memorial Hospital	MOUNT BARKER	5251
Mount Gambier and Districts Health Service	MOUNT GAMBIER	5290
Mount Pleasant District Hospital	MOUNT PLEASANT	5235
Naracoorte Health Service	NARACOORTE	5271
Noarlunga Community Hospital	NOARLUNGA CENTRE	5168
Northern Yorke Peninsula Health Service	WALLAROO	5556
Orroroo and District Health Service	ORROROO	5431
Penola War Memorial Hospital	PENOLA	5277
Peterborough Soldiers' Memorial Hospital and Health Service	PETERBOROUGH	5422
Pinnaroo Soldiers' Memorial Hospital	PINNAROO	5304
Port Augusta Hospital	PORT AUGUSTA	5700
Port Broughton District Hospital and Health Services	PORT BROUGHTON	5522
Port Lincoln Health Services	PORT LINCOLN	5606
Port Pirie Regional Health Service	PORT PIRIE	5540
Quorn Health Services	QUORN	5433
Renmark Paringa District Hospital	RENMARK	5341
Repatriation General Hospital	DAW PARK	5041
Riverland Regional Health Service	BERRI	5343
Riverton District Soldiers Memorial Hospital	RIVERTON	5412
Roxby Downs Health Service	ROXBY DOWNS	5725
Royal Adelaide Hospital	ADELAIDE	5000
Snowtown Hospital	SNOWTOWN	5520
South Coast District Hospital	VICTOR HARBOUR	5211
St Margaret's Rehabilitation Hospital	SEMAPHORE	5019
Strathalbyn and District Health Service	STRATHALBYN	5255

Hospital	Suburb/Town	Postcode
Streaky Bay Hospital	STREAKY BAY	5680
Tailem Bend District Hospital	TAILEM BEND	5260
Tanunda War Memorial Hospital	TANUNDA	5352
The Mannum District Hospital	MANNUM	5238
The Murray Bridge Soldiers Memorial Hospital	MURRAY BRIDGE	5253
The Queen Elizabeth Hospital	WOODVILLE	5011
The Whyalla Hospital and Health Services	WHYALLA	5600
Torrens House	ADELAIDE	5000
Tumby Bay Hospital & Health Services	TUMBY BAY	5605
Waikerie Health Services	WAIKERIE	5330
Women's and Children's Hospital	NORTH ADELAIDE	5006
Woomera Community Hospital	WOOMERA	5720
Wudinna Hospital	WUDINNA	5652
Yorketown Hospital	YORKETOWN	5576

WA

Hospital	Suburb/Town	Postcode
Albany Hospital	ALBANY	6330
Armadale Kelmscott Memorial Hospital	ARMADALE	6112
Augusta Hospital	AUGUSTA	6290
Bentley Health Service	BENTLEY	6102
Beverley Hospital	BEVERLEY	6304
Boddington Hospital	BODDINGTON	6390
Boyup Brook Soldiers Memorial Hospital	BOYUP BROOK	6244
Bridgetown Hospital	BRIDGETOWN	6255
Broome Hospital	BROOME	6725
Bruce Rock Memorial Hospital	BRUCE ROCK	6418
Bunbury Hospital	BUNBURY	6230
Busselton Hospital	BUSSELTON	6280
Carnarvon Hospital	CARNARVON	6701
Collie District Hospital	COLLIE	6225
Corrigin Hospital	CORRIGIN	6375
Cunderdin Hospital	CUNDERDIN	6407
Dalwallinu Hospital	DALWALLINU	6609
Denmark Hospital	DENMARK	6333
Derby Hospital	DERBY	6728
Dongara Multi-Purpose Health Centre	DONGARA	6525
Donnybrook Hospital	DONNYBROOK	6239
Dumbleyung Hospital	DUMBLEYUNG	6350
Esperance Hospital	ESPERANCE	6450
Exmouth Hospital	EXMOUTH	6707
Fitzroy Crossing Hospital	FITZROY CROSSING	6765
Fremantle Hospital and Health Service	FREMANTLE	6160
Geraldton Hospital	GERALDTON	6530

Hospital	Suburb/Town	Postcode
Gnowangerup Hospital	GNOWANGERUP	6335
Goomalling Hospital	GOOMALLING	6460
Graylands Selby-Lemnos & Special Care Hospital	CLAREMONT & SHENTON PARK	6010
Halls Creek Hospital	HALLS CREEK	6770
Harvey District Hospital	HARVEY	6220
Kalamunda Hospital	KALAMUNDA	6926
Kalbarri Health Service	KALBARRI	6536
Kalgoorlie Hospital	KALGOORLIE	6430
Katanning Hospital	KATANNING	6317
Kellerberrin Memorial Hospital	KELLERBERRIN	6410
King Edward Memorial Hospital	SUBIACO	6008
Kojonup Hospital	KOJONUP	6395
Kondinin Hospital	KONDININ	6367
Kununoppin Hospital	KUNUNOPPIN	6489
Kununurra Hospital	KUNUNURRA	6743
Lake Grace Hospital	LAKE GRACE	6353
Laverton Hospital	LAVERTON	6440
Leonora Hospital	LEONORA	6438
Margaret River Hospital	MARGARET RIVER	6285
Meekatharra Hospital	MEEKATHARRA	6642
Merredin Hospital	MERREDIN	6415
Moora Hospital	MOORA	6510
Morawa Hospital	MORAWA	6623
Mullewa Hospital	MULLEWA	6630
Murray District Hospital	PINJARRA	6208
Nannup Hospital	NANNUP	6275
Narembeen Hospital	NAREMBEEN	6369
Narrogin Hospital	NARROGIN	6312
Newman Hospital	NEWMAN	6753
Nickol Bay Hospital	KARRATHA	6714
Norseman Hospital	NORSEMAN	6443
North Midlands Hospital	THREE SPRINGS	6519
Northam Hospital	NORTHAM	6401
Northampton Hospital	NORTHAMPTON	6535
Onslow Hospital	ONSLOW	6710
Osborne Park Hospital	STIRLING	6021
Paraburdoo Hospital	PARABURDOO	6754
Pemberton Hospital	PEMBERTON	6260
Pingelly Hospital	PINGELLY	6308
Plantagenet Hospital	MOUNT BARKER	6324
Port Hedland Hospital	PORT HEDLAND	6721
Princess Margaret Hospital	SUBIACO	6008
Quairading Hospital	QUAIRADING	6383
Ravensthorpe Hospital	RAVENSTHORPE	6346
Rockingham General Hospital	COOLOONGUP	6168
Roebourne Hospital	ROEBOURNE	6718
Royal Perth Hospital	PERTH	6000
Sir Charles Gairdner Hospital	NEDLANDS	6009
Southern Cross Hospital	SOUTHERN CROSS	6426
Swan Districts Hospital	MIDDLESWAN	6056
Tom Price Hospital	TOM PRICE	6751
Wagin Hospital	WAGIN	6315

Hospital	Suburb/Town	Postcode
Warren Hospital	MANJIMUP	6258
Wickham Hospital	WICKHAM	6720
Wongan Hills Hospital	WONGAN HILLS	6603
Wyalkatchem Hospital	WYALKATCHEM	6485
Wyndham Hospital	WYNDHAM	6740
York Hospital	YORK	6302

TAS

Hospital	Suburb/Town	Postcode
Beaconsfield District Health Service	BEACONSFIELD	7270
Campbell Town Multipurpose Centre	CAMPBELL TOWN	7210
Deloraine District Hospital	DELORAINE	7304
Detoxification Centre	NEW TOWN	7008
Esperance Multipurpose Centre	DOVER	7117
Flinders Island Multipurpose Centre	WHITEMARK	7255
George Town Hospital and Community Centre	GEORGE TOWN	7253
Howard Hill Centre	LONGFORD	7301
Huon Eldercare	FRANKLIN	7113
King Island District Hospital and Health Centre	CURRIE	7256
Launceston General Hospital	LAUNCESTON	7250
May Shaw Health Centre	SWANSEA	7190
Mersey Community Hospital	LATROBE	7307
Midlands Multipurpose Health Centre	OATLANDS	7120
Milbrook Rise	NEW NORFOLK	7140
Mistral Place	HOBART	7000
New Norfolk District Hospital	NEW NORFOLK	7140
North East Soldiers Memorial Hospital and Community Services Centre	SCOTTSDALE	7260
North West Regional Hospital	BURNIE	7320
Ouse District Hospital	OUSE	7140
Roy Fagan Centre	LENAH VALLEY	7008
Royal Hobart Hospital	HOBART	7000
Smithton District Hospital	SMITHTON	7330
St Helens District Hospital	ST HELENS	7216
St Marys Health Centre	ST MARYS	7215
Tasman Multipurpose Centre	NUBEENA	7184
Toosey Aged and Community Care	LONGFORD	7301
West Coast District Hospital	QUEENSTOWN	7467
Whittle Ward, Repatriation Centre	HOBART	7000
Wilfred Lopez Centre	RISDON VALE	7016

NT

Hospital	Suburb/Town	Postcode

Hospital	Suburb/Town	Postcode
Alice Springs Hospital	ALICE SPRINGS	870
Gove District Hospital	NHULUNBUY	880
Katherine Hospital	KATHERINE	850
Royal Darwin Hospital	TIWI	810
Tennant Creek Hospital	TENNANT CREEK	860

ACT

Hospital	Suburb/Town	Postcode
Calvary Public Hospital ACT	BRUCE	2617
Queen Elizabeth II Family Centre	CURTIN	2605
The Canberra Hospital	GARRAN	2605

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-126

OUTCOME 13: Acute Care

Topic: INFRASTRUCTURE SPENDING ON PUBLIC HOSPITALS FROM HHF

Hansard Page: CA 120-121

Senator Boyce asked:

a) How many hospitals were there?
b) Where are they?
c) How much money is going towards more hospitals or bigger hospitals over the forward estimates?

Answer:

a) Ten hospitals were provided funding under the Health and Hospitals Fund (HHF).

b) The hospitals are located in Townsville, Rockhampton, Perth (Fiona Stanley Hospital Health Campus and the Midland Health Campus), Broome, Alice Springs, Darwin, Launceston, Narrabri and Penrith.

c) Over the forward estimates, $965.3 million is being provided to these hospital infrastructure projects under the HHF.

Lifehouse at RPA (Sydney, New South Wales) and the Parkville Comprehensive Cancer Centre (Melbourne, Victoria) are integrated cancer centres rather than hospitals, and were funded under the National Cancer Statement component of the HHF in the 2009-10 Budget. Lifehouse will receive a total of $150 million over three years (with $100 million from the HHF and $50 million from the 2008-09 Budget). Parkville will receive $426.1 million from the HHF over five years.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-124

OUTCOME 13: Acute Care

Topic: NATIONAL BLOOD ARRANGEMENTS

Senator Cormann asked:

a) How much funding will be made available for the projects that are mentioned to improve transfusion appropriateness, reduce wastage, deliver better outcomes for patients?
b) Where will those projects be located?
c) What sorts of projects are we talking about?
d) How these projects will be developed and who will be involved?

Answer:

a – d)

The table below provides details on projects to be undertaken in 2009-10 in response to the above question referenced at page 324 of the 2009-10 Portfolio Budget Statements.

Project name/location and description	Nature of Project -	Total Estimated Expenditure in 2009-10	External parties involved	How/why the project was/will be developed
NBA Managed National Projects				
Blood Measures	Involves the development of a standardised set of measures for use in clinical studies, audits and registries that evaluate fresh blood clinical effectiveness. Will allow comparability between studies of fresh blood usage – potentially addressing the dearth of information on the effectiveness of fresh blood transfusions	$60,000	• ARCBS (as joint managers) • 8 practicing clinicians representing a range of specialities involving blood use	In response to concerns of clinicians to have better and consistent data to understand outcomes for patients
Fresh Blood Management Guidelines	To provide evidence based clinical guidelines on patient blood management for specific clinical scenarios: - perioperative - critical bleeding - obstetrics - neonates/paediatrics - medical	$ 1,200,000	• ANZ Society of Blood Transfusion - chair of Expert Working Group • NHMRC • A range of other specialist colleges and societies and expert individual clinicians	In recognition by NBA, NHMRC and ANZSBT that the current guidelines were outdated and did not represent emerging best practice
Haemovigilance Capability development (within the new Haemovigilance Program)	This project involves developing state based reporting capabilities and national governance frameworks for a voluntary haemovigilance program for Australia. The ongoing program is designed to report on serious transfusion related adverse events occurring in public and private hospitals.	$116,943	The Haemovigilance Advisory Committee comprises individuals from; • Australia & NZ Society for Blood Transfusion • State Departments of Health • Australian Private Hospitals Association • Australian Association of Pathology Practices • Private Pathology • Transfusion nursing staff • TGA • Australian Council for Safety and	This initiative is in response to clinical and government concerns to better understand peri-transfusion errors, incrementally improve safety and quality, and ultimately deliver better transfusion outcomes for patients.

Project name/location and description	Nature of Project -	Total Estimated Expenditure in 2009-10	External parties involved	How/why the project was/will be developed
			Quality in Health Care • ARCBS • Australian Institute of Health and Welfare	
Red Cell utilisation	Development of methodology for and specifications of data to be obtained through data linkage projects to understand red cell usage patterns in Australia with the objective of publishing a national report on red cell usage	$150,405 .	Every jurisdiction has indicated a willingness to participate. The RBC Utilisation Working Group comprises individuals from; • WA Department of Health • SA Department of Health • VIC Department of Human Services • Clinical Excellence Commission, NSW • ARCBS • Australian Institute of Health and Welfare	Three major factors have generated interest in this issue, namely: • A need to understand scope for managing blood requirements in the event of any ongoing shortage • Emerging evidence of a high level of variation in blood prescribing practices and • increased concern at the inherent risks of receiving a transfusion when not clinically indicated
National Patient Blood Management Program (NPBMP)development.	To increase awareness and uptake of patient blood management practices and to reduce unnecessary transfusions to enhance overall patient outcomes	$240,000	Membership of the steering committee (to be established)will be multidisciplinary, with blood sector expertise and knowledge of blood management quality and safety issues. Independent experts from related fields may also be invited join the committee.	This project recognises that successful clinical practice change requires a multifaceted approach of policy support, evidence and awareness raising.

ARCBS Managed Projects or where ARCBS plays a major advisory role. ARCBS is fully funded for all activities though the NBA/ARCBS Deed of Agreement				
Project name/location and description	**Nature of Project -**	**Total Estimated Expenditure in 2009/2010**	**External parties involved**	**How the project was /will be/developed**
Data improvement -	The key project is the further development of the electronic capture of the outcomes of products and offers ongoing support to hospitals and laboratories and ARCBS by: • identifying and quantifying wastage by product type and blood group, including reasons for product discard • providing data for review at hospital transfusion committee meetings and other fora • providing opportunities for ARCBS to review product packaging and transport arrangements • aggregate data provided on request to jurisdictions for review of wastage	$50,000 – allocated at ARCBS discretion from funding provided as part of Transfusion Medicine Services (TMS) activities under the Deed of Agreement with the NBA	• Hospitals and laboratories nationally • External website/database contractors	In response to Deed requirements to manage supply efficiently and concerns by jurisdictions at wastage and the associated cost of poor inventory management
National iron deficiency expert working group	This project aims to engage the diverse clinical and other (quality and safety) audience to identify barriers to diagnosis and management of iron deficiency and iron deficiency anaemia, which unaddressed lead to inappropriate transfusion practice	$5000	• ANZSBT Clinical Practice Improvement Committee • Jurisdictional transfusion practice improvement collaboratives • Aust Commission Quality and Safety in Healthcare • National Blood Authority (NBA)	This project is in response to emerging evidence that some transfusions are to patients with iron deficiency anaemia, which is treatable with other therapies, including oral and intravenous iron replacement, and therefore the transfusions may be avoidable

Projects relating to fresh blood and plasma product Guidelines review and preparation	ARCBS is involved in a range of projects to ensure appropriate guidelines for product use. These include • Revision of ANZSBT, ARCBS, NZBS irradiation guidelines • Revision of ANZSBT, RCNA administration guidelines • Review of ASTH consensus statement on warfarin reversal • Revision of ACEM guidelines on massive transfusion • Review of the national programme on antenatal RhD prophylaxis, • Review of CMV Ig in pregnancy	$90,000 allocated at ARCBS discretion from funding provided as part of TMS activities under the Deed of Agreement with the NBA	• ANZSBT • NHRMC • NBA • RCNA • Australasian College of Emergency Medicine • Special Societies (e.g. ANZSBT) and Colleges (e.g. RANZCOG, RCPA, RACP) • Hospitals and laboratories • NBA	ARCBS is acknowledged as an expert organisation in the utilisation of blood and blood products and their interaction with other drugs. These guidelines are reviewed at the regular instigation of relevant societies and ARCBS participation is expected through their TMS role funded under the Deed with the NBA.
Clinical research projects:	• ARCBS undertakes a range of research projects to identify options to improve the clinical use and application of specific products.	• $964,000	• These projects typically involve input to or are done in collaboration with universities, hospitals, specialist societies and government	Governments have agreed that a set proportion of the funding provided to ARCBS under the Deed should be provided for research and development Governments are represented by the NBA on the ARCBS R&D committee and provide clear priorities for this research. .
Jurisdictionally Managed Projects.				
Jurisdictional transfusion practice improvement programs	Each state and territory jurisdiction implements a program of activity to drive improved transfusion practice. These programs also provide data, information and best practice examples that are shared through the jurisdictional blood committee to drive the objectives of the Agreement.	State based budgets	• Hospitals • ARCBS • NBA (for some specific projects)	

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June 2009

Question: E09-282

OUTCOME 13: Acute Care

Topic: PUBLIC HOSPITALS

Written Question on Notice

Senator Boyce asked:

The Government will provide $1.5 billion to Australia's hospital system. The Portfolio Budget Statements state that this will be provided to 'key public hospitals'.

a) Which criteria does the department use to determine what is a 'key public hospital'?

b) Can the department provide patient numbers for each hospital that it classes as a 'key public hospital'?

Answer:

a) A number of proposals funded by the Health and Hospitals Fund (HHF) were for public hospital infrastructure projects that will result in significant benefits for the Australian community at the local and national level. Projects that were funded under the HHF were assessed by the HHF Advisory Board as being of national significance as per Principle 1 of the HHF Evaluation Criteria:

Principle 1: Projects should address national infrastructure priorities
Evaluation Criterion 1: Extent to which the proposal addresses national priorities, including that the proposal:

- ensures significant progress will be made in achieving the Commonwealth's reform targets;
- is consistent with or will complement reform activities and assist the Commonwealth in building a health system for the future; and
- will contribute to a balanced infrastructure investment across Australia.

This may include, but is not necessarily limited to, any or a combination of the following:

- projects at particular sites that serve all of Australia;
- multi-site infrastructure that, collectively, serves all of Australia; and
- infrastructure that is regionally specific but which is intended to improve local health care to bring it up to, or closer to, standards enjoyed by Australians in other areas.

b) Not applicable.

Australian Government

Department of Health and Ageing

Mr Elton Humphery
Secretary
Senate Community Affairs Committee
Parliament House
CANBERRA ACT 2066

Dear Mr Humphery

Request for Amendment to Evidence Provided at Budget Hearing, 3 June 2009 : Outcome 13

I am writing to correct a statement that I made at the Budget Estimates hearing of the Senate Community Affairs Committee on 3 June 2009.

Senator ADAMS asked the following question:

"Have any other companies applied to operate or set up a new business?"

My response was as follows:

"Not to my knowledge."

It has been brought to my notice that my answer, which I gave in the context of the preceding question which related to current negotiations with CSL for a new contract, and my interpretation of the word "applied", could be misinterpreted. In light of subsequent consideration the response should now be amended as follows:

"The NBA does not have a function of receiving applications to operate or set up a new business, and to my knowledge the NBA has not received any such application

Yours sincerely

Dr Alison Turner
General Manager
National Blood Authority

18 June 2009

octapharma

For the safe and optimal use of human proteins

June 17th 2009
By email

Senator Clare Moore
Chair
Senate Community Affairs Committee – Legislation
Parliament House
Canberra ACT 2600

Dear Senator,

Senate Committee on Community Affairs Budget Estimates: Blood Sector

Octapharma seeks to provide comment and correct the record on the early June 2009 discussion in Senate Estimates in relation to blood sector matters, specifically:

Senator ADAMS—Do CSL have a tender structure, or how do they provide the service?

Dr Turner—They provide it under a contract, which the NBA manages on behalf of all Australian governments.

Senator ADAMS—Have any other companies applied to operate or set up a new business?

Dr Turner—Not to my knowledge.

Background

Octapharma Australia Pty Ltd (**Octapharma**), with headquarters in Sydney, is a subsidiary of Octapharma Group, which is a major supplier of plasma products world-wide, with activities encompassing R&D, production, sales and distribution. Production facilities are located in Germany, France, Sweden, Austria and Mexico. It competes with CSL Ltd, amongst other players, in world markets. Copies of our annual reports are available at http://www.octapharma.com/corporate/02_the_company/04_financial/04_financial.php and further information on Octapharma Australia is available at http://www.octapharma.com/Australia/index.php

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Jones Bay Wharf
42/26-32 Pirrama Road
Pyrmont NSW 2009
Australia

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In Australia, Octapharma has been advocating the benefits of competition in the blood sector for patients, health care professionals, government and taxpayers, with the aim of supplying alternative plasma products to the Australian market that are innovative, meet the highest standards and are price competitive. This will provide patient choice and security of supply in a market traditionally dominated by a monopoly supplier. To date, Octapharma has successfully licensed 6 plasma derived pharmaceutical products in Australia with the Therapeutic Goods Administration (**TGA**), and has supplied Intravenous Immunoglobulin (IVIg - Octagam) since 2005 to the National Blood Authority (NBA) to meet a domestic shortage under competitive tender arrangements for imported IVIg, but so far has not been permitted by governments to compete with CSL domestic IVIg (IntragamP).

Imported Plasma Products

Octapharma has continuously supplied imported IVIg (Octagam) to Australia since early 2005. There has been no shortage of IVIg in Australia during this time despite a global supply shortage. In addition, Octapharma has made several plasma product funding submissions to the National Blood Authority under Schedule 4 of the National Blood Agreement (for products without an equivalent available - Octaplas, Wilate, Gammanorm and Pronativ) to compete with CSL by supplying these alternative innovative plasma products which have all obtained TGA licenses.

So far, none of these products have been granted funding, even though doing so would provide substantial immediate benefits in terms of obtaining a competitive price, product choice, better range of products and diversity of supply.

Octapharma's Fractionation Plant Proposal

Of particular relevance to the recent Senate Estimates hearing, Octapharma in May 2007 submitted a formal proposal to build a $400M plasma fractionation facility in Australia, in order to compete with CSL Ltd (**CSL**). This followed from the outcomes of the Plasma Fractionation Review (PFR) conducted by the Federal Government, the results of which were published in late 2006. The PFR recommended that fractionation of plasma collected from Australian donors should continue to occur in Australia, rather than be sent overseas for fractionation.

Consequently Octapharma decided to submit a proposal, followed by a business case, to the Australian Government to fractionate Australian plasma in Australia in competition with CSL, the current monopoly supplier. This proposal, the details of which were further clarified by Octapharma on 17th March 2008, was considered by the Jurisdictional Blood Committee (JBC), which is chaired by the Commonwealth Department of Health and Ageing, and includes the NBA as secretariat.

For reasons unknown to us, Octapharma has not received a response to our March 2008 offer, which we believe is in the hands of the Department of Health and Ageing. We view this as peculiar, particularly in light of the world financial crisis and Octapharma's willingness to invest hundreds of millions of dollars in Australia, both in infrastructure and in employment.

Future Monopoly Supply Contract

Australian Health Ministers (AHMC) agreed in 2007 to:

"importing plasma products to address any shortfall and risks in supply of domestically manufactured products. Procurement of imported plasma products should be undertaken .... This may also facilitate benchmarking by the National Blood Authority of domestically manufactured plasma products against prices for imported plasma products, in order to further the objective of value for money in future contract negotiations." [1]

The corresponding implementation strategy states: *"The current fractionation arrangements agreed by the Australian Health Ministers' Conference provide for ... the importation of plasma derived products that either are not manufactured by CSL Bioplasma or, in the case of IVIg, are required in order to augment domestic supply ... There is therefore the opportunity for international fractionators that wish to compete for this contingency supply business to participate in the Australian market."*

We understand that the NBA and CSL are currently negotiating another monopoly supply contract that will cover a five year period from 2010. In our view, this is an anti-competitive arrangement that is likely to disadvantage the Australian taxpayer.

Octapharma hopes that in bringing these budget estimate irregularities to your attention that it may lead to substantial benefits for patients and the taxpayer.

Octapharma would be happy to provide further details in future about the adverse impacts on Australia from the ongoing failure of the JBC to fund several of our TGA registered products for use by patients.

Yours Sincerely,

Simon Sestich
General Manager

Cc: Senator Judith Adams
Cc: Senator Matthias Cormann

[1] Recommendation #3 Plasma Fractionation Review

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-319

OUTCOME 14: Biosecurity and Emergency Response

Topic: THERMAL SCANNERS

Written Question on Notice

Senator Heffernan asked:

AQIS installed thermal imaging scanners at airports to scan for swine flu from incoming passengers:

a) How many scanners have been purchased or did we have these in stock?

b) How much are these scanners?

c) Which Departmental budget is picking up the tab for the scanners, is it DAFF (AQIS), DITRSLG, Sydney airport?

d) How accurate are these scanners?

Answer:

a) The Department of Health and Ageing purchased 25 thermal scanners in December 2004.

b) Each thermal scanner and associated equipment (battery charger, tripod and carry bag, protective case and TV monitor) cost $20,686 (GST inclusive).

c) The Department of Health and Ageing.

d) Thermal imaging scanners are accurate to within + or – 2 % of target temperature or 2 degrees celsius whichever is greater.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-158

OUTCOME 14: Biosecurity and Emergency Response

Topic: H1N1 INFLUENZA 09 OUTBREAK - DAWN PRINCESS

Hansard Page: CA 47-48

Senator Back asked:

RE the ***Dawn Princess*** cruise ship berthing Sydney 23 May 2009:

a) What was the port of origin of that particular voyage?

b) And also its date of departure.

c) At what point would the department have been informed of the likelihood or possibility of there having been people with flu-like symptoms on board the vessel. It would be of some use to me if I could actually receive on notice the details of that communications flow, for my assistance.

d) So presumably tests were taken. Were those results back prior to the time that passengers and crew disembarked from the vessel on 23 May?

e) Can you confirm , or otherwise, the reports in the media that there are a number of positives for H1N1 from that voyage of the Dawn Princess?

Answer:

a) The Dawn Princess departed on a 35 day South Pacific cruise from Sydney.

b) 18 April 2009.

c) Following advice from Australian Quarantine and Inspection Service (AQIS) under the conditions of positive pratique, NSW Health advised the NIR at around 1.00pm on 21 May 2009 that they were requesting AQIS to hold the Dawn Princess from docking in Sydney. Several teleconferences were held with NSW Health that afternoon.

d) Two passengers had tested positive for Influenza A, were treated with Tamiflu and fully recovered before docking in Sydney. All additional tests taken on board were negative for Influenza A of any type. These facts were clear at the point passengers and crew disembarked from the vessel.

e) There were no positive H1N1 cases on this voyage.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-159

OUTCOME 14: Biosecurity and Emergency Response

Topic: H1N1 INFLUENZA 09 OUTBREAK – PACIFIC DAWN

Hansard Page: CA 49

Senator Back asked:

RE the ***Pacific Dawn*** cruise ship berthing Sydney 25 May 2009:
I understand that there were two young Victorian boys, one five and one six, who alighted from the vessel. One of them got onto a commercial airline and flew down to Melbourne with his family and other passengers.

a) Would we be satisfied as to his level of quarantine at that time?
b) Since there seems to be silence from the 24th to the 26th, when did the department alert the public to the outcome of those positive tests from the Pacific Dawn, which berthed on the 23rd?
c) Re New Caledonia: ….as a result of the fact that the indication apparently from the medical officer on board was that there was nobody suffering any influenza or respiratory like symptoms, and on this basis the vessel did berth. Is it within the scope of the department to check that there was not a breakdown in procedures there?

Answer:

a) Yes. Prior to his departure for Melbourne on 25 July no positive H1N1 test results had been received from the Pacific Dawn. The boy and his family were administered Tamiflu as they had tested positive at the point of care to Influenza A, and flew to Melbourne where he presented to the Alfred Hospital and was placed in home isolation. The basis of the decision to release passengers was that all passengers had originally departed from Australia and did not meet the case definition at the time of travel to an infected country. The vessel had not visited any countries where H1N1 was prevalent and that the vessel had originally departed from Sydney.

b) The Pacific Dawn berthed in Sydney at 0615 on 25 May 2009. At the time of berthing NSW Health had been advised of 13 cases of influenza like illness on board with six positive point of care tests for Influenza A on board. The vessel was initially held in quarantine while passengers were tested for H1N1 Influenza 09. Disembarkation commenced at 0800 on 25 May, and was completed by 1030. Passengers with flu like symptoms and their families were disembarked wearing masks and separately from other passengers. Results confirming that two children had H1N1 Influenza 09 were confirmed at 1800.

NSW Health was responsible for investigating the potential outbreak and releasing public information. NSW Health issued a media release on 25 May informing the public of the first two positive cases for pandemic (H1N1) 2009. At 1450 on May 26 the scripts provided by the Department to the H1N1 09 public information hotline had been updated and the Department's website was updated with information provided by NSW Health on 27 May 2009.

c) In responding to outbreaks on board the Pacific Dawn the Department followed appropriate procedures as laid down in the International Health Regulations and the National Health Security Act 2007. Before berthing in New Caledonia the captain of the Pacific Dawn reported to New Caledonian authorities that there were no passengers with influenza-like-symptoms on board.

After confirmation of pandemic (H1N1) 2009 cases on board the Pacific Dawn in Australia on 25 May 2009, the Department notified the WHO in accordance with the International Health Regulations at 1132 on 26 May and provided DFAT with information for inclusion in cables to Vanuatu and New Caledonia. The Department therefore followed procedures appropriately.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-162

OUTCOME 14: Biosecurity and Emergency Response

Topic: NATIONAL ACTION PLAN FOR HUMAN INFLUENZA PANDEMIC

Hansard Page: CA 46 & 53

Senator Back asked:

a) On what date was the National Action Plan for Human Influenza Pandemic been activated?
b) Does the National Pandemic Emergency Committee have its authority as a result of the national action plan?
c) Is the National Pandemic Emergency Committee now active?

Answer:

a) The National Action Plan (NAP) for Human Influenza Pandemic is a whole of government plan which has been in place since July 2006. A revised version of the plan was agreed by COAG on 30 April 2009. The NAP is currently guiding Australia's national response to the H1N1 09 virus outbreak.

b) Yes.

c) Yes.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-164

OUTCOME 14: Biosecurity and Emergency Response

Topic: H1N1 INFLUENZA 09 – HOTLINE STATISTICS

Hansard Page: CA 58

Senator Back asked:

Would it be possible to be provided with some advice on the number of calls, just to have some indication?

Answer:

64,936 calls were made to the hotline up to 17 July 2009.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-163

OUTCOME 14: Biosecurity and Emergency Response

Topic: H1N1 INFLUENZA 09 – NATIONAL MEDICAL STOCKPILE

Hansard Page: CA 54

Senator Back asked:

a) What items, drugs and equipment, are reserved which would be applicable in an outbreak of this nature?
b) What are the current levels of each of these prior to the first case being reported?
c) What are the volumes of drugs and equipment that have been allocated to date?

Answer:

The following table itemises applicable stock, initial quantities and volumes allocated as at 20 August 2009.

NATIONAL MEDICAL STOCKPILE INVENTORY AND DEPLOYMENTS FOR H1N1 Influenza A

Item	Stock held as at April 24	Stock to be received after April 24	Stock deployed up to 20 August 2009
Tamiflu *(courses)*			
Capsules 75 mg	3,875,400	Nil	744,440
Capsules paediatric	Nil	56,000	Nil
Suspension paediatric	56,000	Nil	51,598
Powder (approximate courses)	3,010,400	Nil	71,000
Relenza *(courses)*	1,833,000	1,600,000	32,000
PPE			
P2 respirators	1,519,680	14,412,160	142,840
Surgical gowns	2,863,300	Nil	88,800
Surgical masks	39,984,000	Nil	1,433,000
Examination gloves	45,916,300	Nil	422,000
Goggles	685,008	Nil	31,392
Alcohol hand rub	23,715	Nil	4,020

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 & 4 June, 2009

Question: E09-113

OUTCOME 15: Sport

Topic: AIS SCHOLARSHIPS

Hansard Page: CA 31

Senator Fifield asked:

a) How many full-time and part-time scholarships has the AIS awarded in this financial year? Let's take this financial year and the previous financial year.
b) How many scholarships did the state institutes and academies award in the same two financial years?
c) How many full-time and part-time scholarships do the AIS expect to award in 2009-10?
d) And how many scholarships do the state sports institutes and academies expect to award in 2009-10?

Answer:

a) In 2007-08 the AIS awarded 627 full-time athlete scholarships. The AIS did not award any part time scholarships. For the current financial year, as at 10 June 2009, the AIS has awarded 692 full-time athlete scholarships. The AIS has not awarded any part time scholarships.

b) Information provided by the National Elite Sports Council details that state and territory institutes and academies of sport collectively awarded 2,690 athlete scholarships in 2007-08. The number of athlete scholarships awarded by state and territory institutes and academies of sport for 2008-09 has not yet been provided by the National Elite Sports Council.

c) In 2009-10 the AIS expects to have the capacity to award appropriately 700 full time athlete scholarships.

d) The AIS is not involved in the determination of state and territory institutes and academies of sport athlete scholarships. Subsequently the AIS is unaware how many scholarships are expected to be awarded by these agencies in 2009-10.

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-150

OUTCOME 15: Sport

Topic: INDEPENDENT SPORT PANEL

Hansard Page: CA 22-25

Senator Fifield asked:

With respect to the consultation process conducted by the Independent Sport Panel, would it be possible to obtain:

a) a copy of the advertisement and any associated media release that notified of the call for public submissions;

b) information of where these advertisements were placed in the media;

c) advice on when the last meeting was held with stakeholders;

d) information on when the committee first decided to hold a second round of submissions or to call for a second round of submissions and when the public were first notified that there would be a second call for submissions

e) a copy of the advertisements and any associated media releases regarding the community sport consultations; and

f) a list of those organisations that attended the community sport public forums.

Answer:

a) Copies of the advertisements for the Independent Sport Panel's call for submissions in 2008 and 2009 respectively are at Attachment A and B.

b) The call for public submissions in 2008, which invited comments on both elite and community sport, was advertised in the following national newspapers: *Canberra Times; Sydney Morning Herald; The Age; Courier Mail; Adelaide Advertiser; West Australian; Hobart Mercury;* and *Northern Territory News.*

The call for public submissions in 2009, which focussed on community sport, was advertised in the following newspapers: *The Australian; Adelaide Advertiser; Brisbane Courier Mail, Canberra Times; Northern Territory News; Hobart Mercury; The Age; West Australian; Sydney Morning Herald; Albury Border Mail; Coffs Coast Advocate; Dubbo Daily Liberal;* and *Cairns Post*.

The Independent Sport Panel also advised that the Sport Panel was inviting submissions on their website (www.sportpanel.org.au).

In addition, the Australian Sports Commission advised National Sporting Organisations (NSOs) of the call for submissions on 29 September 2008 and again on 4 March 2009.

c) The Independent Sport Panel's last meeting with stakeholders was 11 August 2009.

d) At its 22 January 2009 meeting the Independent Sport Panel endorsed the community consultation process for 2009.

On 28 February 2009 (with the exception of Dubbo which was announced on 4 March 2009) the Independent Sport Panel announced there would be a further call for public submissions that focussed on community sport. A copy of the announcement is at Attachment B.

e) Advertising for the community sport consultations consisted of:
   i) a public announcement advising where the community sport consultations would be held. A copy of the advertisement is at Attachment B.
   ii) an advertisement on the preceding weekend of each public forum placed in the local newspaper. A copy of the advertisement is at Attachment C.

f) A list of the organisations that attended the community sport public forums is at Attachment D.

Australian Government
Department of Health and Ageing

INDEPENDENT SPORT PANEL

CALL FOR SUBMISSIONS

The Minister for Sport, Kate Ellis, announced on the 28 August 2008, the appointment of an independent expert panel (Sport Panel) to investigate and report on the measures required to ensure that Australia's sporting system remains prepared for the challenges of the future, at the elite and grassroots levels.

The Sport Panel is seeking comment from organisations and individuals with an interest in identifying new direction in two key areas: management of elite sport and increasing community participation and physical activity.

Submissions must address the terms of reference. For more information please visit the website of the Sport Panel at www.sportpanel.org.au

Submissions must be lodged in writing on the website of the Sport Panel. The website will accept submissions from 3 October 2008. Closing date for submissions will be 7 November 2008.

Call for Submissions advertisements ran in the following papers on 27 September 2008:

- Canberra Times
- Sydney Morning Herald
- The Age
- Courier Mail
- Adelaide Advertiser
- The West Australian
- Hobart Mercury
- Northern Territory News

Australian Government

Department of Health and Ageing

INDEPENDENT SPORT PANEL

COMMUNITY SPORT CONSULTATION PROCESS MARCH - MAY 2009

The Minister for Sport, Hon. Kate Ellis appointed an Independent Expert Sport Panel (Sport Panel) in August 2008 to investigate and report on the measures required to ensure that Australia's sporting system remains prepared for the challenges of the future, at the elite and grassroots levels. As part of the examination, the Sport Panel is consulting widely.

In 2008 the Sport Panel conducted an extensive public submissions process, with a focus on elite sport. The submissions are now available on the Sport Panel website at: www.sportpanel.org.au.

The Sport Panel is now conducting its 2009 community sport consultation process. As a part of this process the Sport Panel will hold a second public submissions process that will focus on community sport. The submissions process will be open from 2 to 27 March 2009. For further information or to make a submission please refer to the Sport Panel website.

The Sport Panel will also hold public forums from March to May in Darwin, Sydney, Albury/Wodonga, Hobart, Brisbane, Cairns, Coffs Harbour, Adelaide, Melbourne, Canberra, Dubbo, Perth and Albany. Further details including dates, locations and venues are available on the Sport Panel website.

Places are limited so please RSVP your attendance and preferred location to spsupport@health.gov.au

hma095703

Call for Consultation Process advertisements ran in the following papers

NEWSPAPER	DATE
The Australian	28 February 2009
Adelaide Advertiser	28 February 2009
Brisbane Courier Mail	28 February 2009
Canberra Times	28 February 2009
Northern Territory News	28 February 2009
Hobart Mercury	28 February 2009
Melbourne Age	28 February 2009
West Australian	28 February 2009
Sydney Morning Herald	28 February 2009
Albury Border Mail	28 February 2009
Coffs Coast Advocate	28 February 2009
Dubbo Daily Liberal	4 March 2009
Cairns Post	28 February 2009

Attachment C

INDEPENDENT SPORT PANEL
COMMUNITY SPORT CONSULTATION PROCESS
PUBLIC FORUM DATE, 7:00 PM TO 10:00 PM

VENUE

The Minister for Sport, Hon. Kate Ellis appointed an Independent Expert Sport Panel (Sport Panel) in August 2008 to investigate and report on the measures required to ensure that Australia's sporting system remains prepared for the challenges of the future, at the elite and grassroots levels.

The Sport Panel is consulting widely and is now conducting a consultation process that will focus on community sport and participation in sport. A public forum is being held at the above location for all interested parties. The forums will provide participants with the opportunity to identify and discuss issues which are based on the Panel' Terms of Reference.

Further information on the Sport Panel including the Terms of Reference is available on its website at www.sportpanel.org.au.

Call for attendance at Public Forum advertisements rang in the following papers:

NEWSPAPER	DATE
Northern Territory News	21 March 2009
Daily Telegraph	28 March 2009
Albury Border Mail	28 March 2009
Hobart Mercury	28 March 2009
Courier Mail	28 March 2009
Cairns Post	4 April 2009
Adelaide Advertiser	11 April 2009
Melbourne Age	11 April 2009
Canberra Times	11 April 2009
West Australia	18 April 2009
Dubbo Daily Liberal	25 April 2009
Coffs Harbour Advocate	25 April 2009

Attachment D

Community Sport Public Forums - Attended Organisations
A Balanced View Leisure Consultancy Services
ACT Little Athletics Association Inc
ACT Rugby Union
ACTSPORT
AFL ACT/NSW
Albury-Wodonga Community College
Aquatic and Leisure Institute
Aquatics and Recreation Victoria
Archery Society of WA
Archery Tasmania
Armidale City Council
Athletics Queensland
Athletics Tasmania
Australian Athletes with a Disability
Australian Bureau of Statistics
Australian Drug Foundation
Australian Flying Disc Association
Australian Hockey League
Australian Leisure Facilities
Australian Little Athletics
Australian Oztag Sports Association
Australian Red Cross
Australian Sports Commission
Australian Water Polo
Australian Womens Studying Resources Association
Baseball WA
Basketball Australia
Basketball Tasmania
Bayside City Council
Bowls ACT
Bowls Australia
Bowls WA
Brisbane City Council, Families & Community Services
Cairns Council
Cairns Crocs Triathlon
Cairns Regional Council, Community & Cultural Services
Camberwell Hockey Club
Central Hockey Club Inc
City & Park Lands Planning
City of Albany Council
City of Casey Shire Council
City of Stonnington Council
City of Swan
City of Unley Shire Council
Coffs Harbour City Council
Coffs Harbour Sports Advisory Council
Commonwealth Department of Education, Employment and Workplace Relations
Council of the Ageing and Powerlifting Australia
Cricket ACT
Deafsports Victoria
Department of Education

Doublas United FC
Dubbo & District Soccer Association Inc
D-Volleyball SA Inc
East Arnhem Shire Council
Equestrian WA
Far-Western Academy of Sport
FIBA (International Basketball Federation) Oceania Basketball
Football Federation Victoria
Gala Entertainment Management Australian Institute of Circus Arts
Girls Sport Victoria
Glenorchy City Council
Golf NT
Golf SA
Great Southern Football League
Great Southern Regional Cricket Board
Griffith University
GSPORT Consultancy
Gymnastics SA
Hockey Australia
IMG Sports Promoters & Consultants - Tennis
Kim Cooper Consulting
Kingborough Sports Centre
La Trobe University, School of Management
Little Athletics Association of NSW
Logan City Council
Manningham City Council
Mature Artists Dance Experience Inc
Member of Albany
Mountain Bike Australia
Mpower dome - Indoor Sports Centre
Murray/Mallee Community Health Service
National Institute of Circus Arts
Netball Australia
Netball Victoria
New South Wales Netball Association Limited
Newcastle University Sport (Nusport)
North Brisbane Junior Rugby Club
North Cottesloe Surf Lifesaving Club
Northern Territory Hockey Association
Noyoongar Sports Association
NSW Combined High Schools Sports Association
NSW Department of Education, Combined High Schools Sports Association
NSW Department of Sport & Recreation
NSW Rugby League Academy
NSW Sport & Recreation, Lake Burrendong Sport & Recreation Centre
Nunawading Swimming Club
Nutmegs Football Academy
OAMPS Insurance Brokers
Office for Recreation and Sport
OneEighty Sport & Leisure Solutions
Orange Schools Office
Orienteering Association of SA
Orienteering Queensland
Parks and Leisure Australia (SA and NT regions)
Penrith City Council

Perth YMCA
Police Citizens Youth Club QLD
Pony Club Association of Western Australia Inc
Port Augusta City Council
Qsport - Sport Federation of Queensland
Queensland Athletics
Queensland Country Cricket Association
Queensland Department of Communities
Queensland Department of Local Government, Sport and Recreation
Queensland School Sport Unit
Queensland Ultimate Disc
Queensland Ultimate Disc Association
Recreation Training QLD
Rockdale City Council
Ross Planning - Recreation, Open Space and Sports Planning
Rowing Australia
Rowing Queensland Inc
Royal Life Saving Society Australia
Royal New South Wales Bowling Association
RWM Consultancy
School Sport Australia
School Sport Victoria, Department of Education and Early Childhood Development
Scouts Australia New South Wales
Service Skills Australia
Shepparton Sports Stadium
Shire Councils of Gnowangerup, Kent, Broomehill, Tambelup & Kojonup
Shire of Mundaring, Recreation and Leisure Services
Smart Connection
South Australia Department of Education and Children's Services
South Australia Flying Disk Association
South Australian Little Athletics
South Australian Sports Institute
South Australian Water
South Canberra Gymnastics Club
South East Local Government Association
South Queensland Archery Society Inc
South West Academy of Sport
South Western Metro Basketball Association Inc
Southern Zone Pony Club, Tasmania
Special O South Aust.
Special Olympics ACT
Special Olympics Victoria
Special Olympics WA
SportBusiness Partners Pty Ltd
Sporting Wheelies
Sports CONNECT - Sporting Wheelies
Sports Medicine Australia (Victorian Branch)
Squash ACT
Strategic Leisure Group
Surf Life Saving Tasmania
Surf Sports and Surf Life Saving NSW
Suter Planners
Swimming Australia
Swimming Victoria

Table Tennis Australia
Tasmanian Department of Health & Human Services
Tasmanian Department of Sport and Recreation
Tasmanian Sports Federation
Tennis ACT
Tennis Australia
Tenpin Bowling Qld
Tenpin Bowling WA
Touch Football Australia
Touch Football South Australia
Touch Football Victoria
Transplant Australia
Triathlon Australia
Triathlon NSW
Triathlon Queensland
Triathlon Victoria
University of Ballarat
University of Canberra (Faculty of Health)
University of Queensland
University of South Australia, School of Health Sciences
Velocity Sports
VicHealth
Vicsport
Victorian Department of Planning & Community Development
Victorian Department of Sport and Recreation
Victorian Golf Association
Victorian Handball Federation
Victorian Water Polo Inc
Vision Impaired Sport ACT
Volleyball Queensland
West Arnhem Shire Council
Western Australia Department of Sport and Recreation
Western Australia Football Commission
Western Australia Little Athletics
Wheelchair Sports WA Association
Whitehorse Netball Association
Women's Golf NSW
Women's Golf Victoria
Womensport Queensland
Yarra Ranges Shire Council
YMCA Australia - Victoria
YMCA of Inner North East Adelaide

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3 June 2009

Question: E09-151

OUTCOME 15: Sport

Topic: SPORT FACILITIES

Hansard Page: CA 28

Senator Fifield asked:

With respect to the 94 contracts administered by the Department of Health and Ageing for sport and recreation facilities under $5million, can the Department advise:

a) the dates that each of the 63 contracts were executed; and

b) for the remainder, which clubs they are and the reasons for the delay?

Answer:

a and b)

The attached table outlines the status of the projects at 1 September 2009.

Sport and Recreation Facilities

Project name	Commitment	Execution Date	Reason for delay at 1 September 2009
Adelaide North East Hockey Club	1,000,000	23/04/09	
Aspley Hornets Sports Club	60,000	22/06/09	
Batemans Bay Rugby Club	10,000	23/12/08	
Bathurst Rugby Union Cricket Club	15,000	09/10/08	
Bathurst Rugby Union Club	15,000	21/04/09	
Bathurst Soccer Club	170,000		Funding moved to 2009-10 at proponent request
Beauty Point Recreation Ground	100,000	03/02/09	
Biloela, Rainbow Street Sporting Fields	50,000		Funding moved to 2009-10 at proponent request
Binalong Park, Toongabbie	150,000	29/06/09	
Blackstone Park Development	170,000	22/01/09	
Blackwood Football Club	130,000	14/05/09	
Bridport Walkway	150,000	26/05/09	
Bunbury - Hands Oval	100,000	01/12/08	
Bundaberg Cricket Association	79,500	10/09/08	
Bungendore Swimming Pool Upgrade	120,000	23/04/09	
Burpengary Jets Junior Football Club	120,000	08/12/08	
Caboolture Snakes Rugby League Club	110,000	22/12/08	
Caboolture Sport Softball Grounds	200,000	11/06/09	
Campese Oval and Taylors Park – Queanbeyan	1,000,000	30/01/09	
Cataract Gorge Walkways	500,000	06/01/09	
Champion Lakes Recreation Site	100,000	14/04/09	
Clontarf South West Football Academy	50,000	24/02/09	
Cook Park Soccer grounds	100,000		Funding moved to 2009-10 at proponent request
Corio Bay Rowing Club	250,000	07/04/09	

Project name	Commitment	Execution Date	Reason for delay at 1 September 2009
Croydon Little Athletics Club	150,000	22/04/09	
Cygnet Gymnasium	35,000	23/06/09	
Dennis Park, Tannum Sands	212,000	30/06/09	
Dolphins Football Club	112,000	27/02/09	
Ellis Beach Surf Club	100,000	23/06/09	
Eurobodalla Netball Association	8,000	22/12/08	
Forrestfield United Soccer Club	125,000	06/01/09	
Gawler Soccer and Sports Club	200,000	30/06/09	
Geelong – Feasibility Study into Regional Soccer Club	20,000	13/05/09	
George Town Feasibility Study	25,000	11/03/09	
Gladstone Hockey Field	200,000		Funding moved to 2009-10 at proponent request
Glen Park Sporting Facilities	500,000	14/05/09	
Golden Grove Central Districts Baseball Club	50,000	26/06/09	
Gosnells Bowling Club	200,000	13/03/09	
Helensburgh Netball Club	50,000		Awaiting further information from proponent
Helensburgh Tennis Club	15,000	23/06/09	
Hidden Valley Motorway	3,000,000	25/02/09	

Project name	Commitment	Execution Date	Reason for delay at 1 September 2009
Ingle Farm Amateur Soccer Club	50,000		Awaiting further information from proponent
Jamison Park Netball Courts	84,000	17/06/09	
Jervis Bay Netball Club	20,000	24/06/09	
Jindabyne Sports Field Upgrade	650,000	10/12/08	
Kingborough Lions United Soccer Club	10,000	27/05/09	
Lapstone Netball Complex	100,000	29/06/09	
Les Hughes Sporting Complex – Pine Central Holy Spirit Rugby League Football Club	35,000	04/12/08	
Les Hughes Sporting Complex – Police Citizens Youth Club	40,000	01/12/08	
Lithgow Hockey	100,000		Funding moved to 2009-10 at proponent request
Low Head to George Town Recreational Trail	750,000	05/05/09	
Macedonia Park	1,000,000	03/02/09	
Mallabula equipment for Rugby League Club	15,000	18/11/08	
Mallacoota Pathways project	550,000	27/02/09	
Marion Sporting Club	1,000,000	15/12/08	
Moore Park Community Hall	66,000	18/02/09	
Morisset Police Citizens Youth Club Outreach Centre	118,000	16/03/09	
Mt Gravatt Youth and Recreation Club	150,000	06/01/09	
Nabiac Pool	135,000	24/03/09	
NSW YWCA	15,000	06/04/09	
Oberon Recreation Facilities	100,000	30/04/09	
Onkaparinga Rugby Club	100,000	23/06/09	
Palm Island, Community Sports Field	200,000		Funding moved to 2009-10 at proponent request

Project name	Commitment	Execution Date	Reason for delay at 1 September 2009
Para Hills West Junior Soccer Club	200,000	11/06/09	
Parramatta Cycle-Ways project	1,500,000		Funding moved to 2009-10 at proponent request
Penrith Valley Regional Sports Centre	250,000	30/06/09	
Penrith Waratah Rugby League Club	50,000	17/06/09	
Perth Football Club	90,000	12/12/08	
Pine Rivers Lightning Baseball Club	35,000	09/12/08	
Pine Rivers United Netball	30,000	11/12/08	
Port Huon Sports Centre	10,000	25/11/08	
Quay Lights Project	50,000	27/03/09	
Redcliffe Police Citizens Youth Club	200,000	15/06/09	
Redlands United Soccer Club	50,000	06/05/09	
Rokeby Cricket Club	10,000	02/12/08	
Scottsdale Bowling Club	170,000	24/11/08	
Smithton Little Athletics Club	30,000	16/02/09	
Somerset Soccer Facilities	125,000	19/12/08	
South Barwon Football and Netball Club	70,000	26/05/09	
Sportsground at Smiths Lake	200,000	19/03/09	
Sturt Baseball Club	20,000	11/12/08	
Surf Lifesaving Education Program, NSW Central Coast	210,000	10/06/09	
Tamar Rowing Club	150,000	12/12/08	
Tea Gardens Skate Park	30,000	19/03/09	
Tea Tree Gully Football Club	500,000	18/06/09	
Toohey Road Bikeway and Forest Guide	200,000	12/03/08	
Townsville and District Junior League Club	50,000	12/12/08	
Townsville City Netball Association	100,000	16/06/09	
Tuncurry Foster Football Club	20,000	19/03/09	
Walker Park Gymnastics	200,000	25/06/09	
West Traralgon Sports Complex	160,000	12/05/09	
WIN Stadium and Entertainment Centre	230,000	25/09/08	
Windsor Park Football Club	370,000	3/02/09	
Women's Sport Facilities - Stirling	546,000	11/06/09	
Total	**20,895,500**	**85**	**9**

Senate Community Affairs Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2009-2010, 3&4 June 2009

Question: E09-237

OUTCOME 15: Sport

Topic: SPORTING CLUBS AND ALCOHOL

Written Question on Notice

Senator Adams asked:

a) In relation to the incident with Mathew Johns, what education is provided to young men in sporting clubs regarding the relationship between alcohol and attitudes to women?
b) Is the Department working with sporting clubs regarding abuse of alcohol and drugs and the supposed drug culture that exists in sport?

Answer:

a) The Australian Government, through the Australian Sports Commission (the Commission), provides funds to national sporting organisations.

   The Commission implements the Harassment Free Sport strategy and supports the Play by the Rules website.

   Importantly, it is a condition of the Commission's funding agreements that national sporting organisations adopt, implement and enforce member protection policies and procedures. These policies assist sport to promote positive behaviour and to prevent and deal adequately with issues around harassment, discrimination, child protection, violence and other forms of inappropriate behaviour.

   The Commission is also investing time and resources to promote the positive aspects of sport. In particular, the Commission is assisting the sport industry to provide a safe, ethical and inclusive culture within sport. This work includes promoting the Essence of Australian Sport initiative which defines the core principles of sport in Australia – Fairness, Respect, Responsibility and Safety. The Essence of Australian Sport reinforces that everyone has a role to play in promoting and modelling good sportsmanship and fair-play values. Every national sporting organisation has endorsed the principles and is expected to uphold them.

   In addition, the Commission, in cooperation with the Office of Women, administers the Sport Leadership Grants and Scholarships for Women program which is designed to provide support for women to pursue accredited training and development in coaching, officiating, governance, media, communications and management. It is expected that this program will assist in delivering more women in senior positions in sport to challenge outdated attitudes towards women and encourage greater respect.

Further, the Commission has also developed "Building a Better Sport: better management practices" – to assist national sporting organisations (NSOs) increase the participation and involvement of women in al areas and all levels. This program looks at capacity building and a whole of sport assessment of increasing opportunities for women within sports. The program has been [piloted with two NSOs Bowls Australia and Golf Australia, and is set to be expanded this year with the inclusion of the National Rugby League.

The Australian Institute of Sport (AIS, a division of the Commission), offers its scholarship athletes social behaviour training, which addresses issues related to the misuse of alcohol.

b) Yes.

On 18 January 2009, the Minister for Sport announced that six major sporting organisations had signed onto a national alcohol code of conduct which outlines responsibilities for both the organisations and individuals in relation to responsible service and consumption of alcohol. Since then, a seventh sport has come on board. The sports organisations are: Australian Football League; Australian Rugby Union; Cricket Australia; Football Federation Australia; National Rugby League; Netball Australia and Swimming Australia

Further, $2 million is being invested in the Club Champions Program to help foster leaders in the promotion of responsible drinking practices within clubs. The Department is working with the seven major sporting organisations (identified above) to help develop and implement the program.

$5.2 million is being invested in the Australian Drug Foundation's Good Sports Program, which is being expanded to support local sporting clubs to build a culture of responsible use of alcohol.

On 26 June 2009, the Australian Government released its Illicit Drugs in Sport National Education & Action Plan (the Action Plan) backed with $20.1 million over four years to help tackle illicit drug use in sport.

To help sports prevent use within their own ranks and in recognition of the impact that sport role models have on the community, the Action Plan will deliver:

- a comprehensive education program for athletes, coaches and support staff;
- funding for out-of competition testing for illicit drugs and results management for National Sporting Organisations; and
- positive sports role models to deliver education and prevention initiatives targeted at the community level.

The Action Plan also includes funding for research to examine issues around illicit drug use in the sporting environment to better understand the issues and inform future policy.