# Community Affairs
# Legislation Committee

## Examination of Additional Estimates 2004-2005

## Additional Information Received

## VOLUME 3

### Outcomes: whole of portfolio, Outcomes 1 and 2

## HEALTH AND AGEING PORTFOLIO

### MAY 2005

Note: Where published reports, etc have been provided in response to questions, they have not been included in the Additional Information volume in order to conserve resources.

# ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF ADDITIONAL EXPENDITURE FOR 2004-2005

Included in this volume are answers to written questions on notice and tabled papers relating to the additional estimates hearing on 17 February 2005

# HEALTH AND AGEING PORTFOLIO

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2004-2005, 2 & 3 June 2004

Question: E04-001

OUTCOME: Whole of Portfolio

Topic: ADVERTISING/PUBLIC INFORMATION PROJECTS

Written Question on Notice

Senator Murray asked:

Please provide a list of all advertising or public information projects currently being undertaken or expected to be undertaken by the department or agency in the course of 2004 where the cost of the project is estimated or contracted to be $100 000 or more, indicating:

(a) the purpose and nature of the project;
(b) the intended recipients of the information to be communicated by the project;
(c) who authorised or is to authorise the project;
(d) the manner in which the project is to be carried out;
(e) who is to carry out the project;
(f) whether the project is to be carried out under a contract;
(g) whether such contract was let by tender;
(h) the estimated or contracted cost of the project.

Answer:

Attached is a list of advertising and public information projects costing $100,000 or more which were undertaken or expected to be undertaken by the department in 2004.

The details for each part of the question were correct at the time the question was asked and a response prepared.

**DEPARTMENT OF HEALTH AND AGEING, Contact Officer: Meredith Fairweather**

**Response to May 2004 Senate Estimates Question from Senator Andrew Murray**

**<u>Current</u> advertising/public information projects (only include advertising projects over $100,000)**

| Project title | (a) Purpose and nature of the project. | (b) Intended recipients of the information to be communicated by the project. | (c) Who authorised the project? | (d) The manner in which the project is to be carried out. | (e) Who is to carry out the project? | (f) Whether the project is to be carried out under a contract. | (g) Whether such contract was let by tender. | (h) The estimated or contracted cost of the project. |
|---|---|---|---|---|---|---|---|---|
| *National Tobacco campaign* | *To reduce the prevalence of smoking among people aged 18-40 years* | *Australian smokers aged 18-40 years* | *Parliamentary Secretary to the Minister for Health and Ageing* | *Television ads* | *Universal McCann – media buy*<br><br>*Creative material produced prior to 2004, agency no longer on contract* | *Yes*<br><br>*Creative material produced prior to 2004, agency no longer on contract* | *Yes* | *$1.63 million* |
| *Strengthening Medicare campaign* | *Inform Australians about the changes to Medicare, including encouraging couples and families to register for the new Medicare Safety Net* | • *Australian community*<br>• *Health professionals*<br>• *Stakeholder organisations including health industry organisations, peak bodies, and health professionals' representative organisations* | *Minister for Health and Ageing* | *Television and press advertising, including NESB radio advertising, and an information booklet* | *Universal McCann – media buy*<br><br>*Whybin TBWA- creative material* | *Yes*<br><br>*Yes* | *Yes*<br><br>*Yes* | *$19.2million* |

Details correct at the time question was asked and response prepared.

**<u>Planned</u> advertising/public information for 2004 (only include advertising projects over $100,000 approved by your Minister)**

| Project title | (a) Purpose and nature of the project. | (b) Intended recipients of the information to be communicated by the project. | (c) Who is to authorise the project. | (d) The manner in which the project is to be carried out. | (e) Who is to carry out the project? | (f) Whether the project is to be carried out under a contract. | (g) Whether such contract was let by tender. | (h) The estimated or contracted cost of the project. |
|---|---|---|---|---|---|---|---|---|
| National Illicit Drug campaign | *Raise awareness of the harms associated with illicit drug use* | • *Youth 12-18*<br>• *Parents and carers*<br>• *General community* | *The Minister for Health and Ageing* | *Mass media advertising (mediums not yet decided)* | *Universal McCann – media buy*<br><br>*Tender process underway to select creative agency* | *Yes* | *Yes* | *$5 million* |

Details correct at the time question was asked and response prepared.

**STAFFING NUMBERS**

| Financial Year | 2003-04* | 2002-03* | 2001-02^ | 2000-01^ |
|---|---|---|---|---|
| Headcount at 30 June | 6,102 | 5,980 | 3,771 | 3,580 |
| ASL | 5,227 | 5,054 | 3,307 | 3,148 |

* Includes core Department, TGA & CRS Australia
^ Includes core Department & TGA

| Financial Year | 1999-2000^ | 1998-99^ | 1997-98# | 1996-97## | 1995-96## |
|---|---|---|---|---|---|
| Headcount at 30 June | 3,287 | 3,168 | 5,419 | 4,968 | 5,623 |
| ASL | 3,067 | 2,766 | 5,084 | 4,868 | 5,966 |

^ Includes core Department & TGA
# Includes core Department (including functions transferred to FACS in October 1998), TGA & CRS Australia
## Includes core Department (including functions transferred to FACS in October 1998), CRS Australia, TGA and AGHS

- The above table provides both the headcount at 30 June and the Average Staffing Level (ASL) for the relevant years.

- Headcount includes any staff member in the Department regardless of whether they are paid, unpaid, operative, inoperative, full-time, part-time, ongoing, non-ongoing or casual staff. The headcount figures are based on a point in time (ie 30 June), while the ASL is the average staffing level over a period of time (ie the financial year to date) based on full-time equivalents.

- At 30 June 2003 the total headcount was 5,980 with an ASL of 5,054. These figures include CRS Australia who joined the Department on 1 July 2002. The headcount figure comprises 4,093 Departmental & TGA staff and 1,887 CRS staff. The ASL figure comprises 3,574 Departmental & TGA staff and 1,480 CRS staff.

- At 30 June 2004 the total headcount was 6,102 with an ASL of 5,227. The headcount figure comprises 4,128 Departmental & TGA staff and 1,974 CRS staff. The ASL figure comprises 3,646 Departmental & TGA staff and 1,581 CRS staff.

- The Departmental and TGA ASL increased by 72 in 2003/04 Financial year. New Policy Proposals such as Medicare Plus, National Illicit Drugs and Focus on Prevention Strategies accounts for an increase of 54.5 ASL. Additional Estimate Measures accounts for the rest of the increase. CRS ASL increased by 101 in 2003/04 Financial year. CRS have seen an increase in programs during this time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-071

OUTCOME: Whole of Portfolio

Topic: CONSULTANCIES

Written Question on Notice

Senator Carr asked:

Please provide a table listing details of all consultancies for the 2003/04 financial year, for the department and all associated agencies. Please include the following:

(a) the costs for all completed consultancies, both budgeted and actual;
(b) the costs for ongoing consultancies, both budgeted and for the current financial year;
(c) the total costs for all consultancies, both the amount expended in the current financial year, and the total budgeted value of all consultancies running in the current financial year;
(d) the nature and purpose of the consultancy;
(e) the method by which the contract was let;
(f) the name and details of the company and/or individual who is carrying out, or carried out, the contract.

Answer:

(a) (b) and (c)

The Department of Health and Ageing (the department) publishes details of consultancies approved in a given financial year in that year's Annual Report. For the 2003-04 financial year the details of consultancies approved are shown at Appendix 7 on page 463. The contract price reported is in effect the budgeted cost for the contract. The Annual Report details all consultancy contracts approved during the financial year that are greater than $10,000.

The details of each consultancy reported in the Annual Report includes the name of the consultant, the justification and selection process, the contract price and the purpose of the consultancy. Similar information is provided in the department's Annual Reports for prior years.

The department also publishes details on both the number of consultancies and the total paid in a financial year. For the 2003-04 financial year these details are provided in the department's Annual Report at page 462. Similar information is provided in the department's Annual Reports for prior years.

To calculate and report each consultancy's actual and budgeted costs would take significant resource effort and the department is not currently in a position to undertake this work.

(d) (e) and (f)

The department's 2003-04 Annual Report provides information on the purpose, selection process and details of the consultant providing the services for all approved and reportable consultancies. This information is provided at Appendix 7 of this year's report and starts on page 463. Similar information is provided in the department's Annual Reports for prior years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-093

OUTCOME: Whole of Portfolio

Topic: INCREASE IN STAFFING LEVELS FROM 2002-03 to 2003-04

Hansard Page: CA 124

Senator McLucas asked:

Can you provide the increase in staff numbers from 2002-03 to 2003-04 and the number of increased staff related to new policies .

Answer:

The following table provides the Average Staffing Level (ASL) for the relevant financial years. ASL is defined as the average of full time equivalent staffing for each month of the financial year.

| | **2003-04*** | **2002-03*** |
|---|---|---|
| ASL | 3,646 | 3,574 |

*Includes core department & Therapeutic Goods Administration

The following table provides a more detailed breakdown of the increase in funded ASL for the 2003-04 financial year:

| **2003-04 Budget Measures**<br><br>Major Program Initiatives | **2003-04 New Policy Proposals** | **2003-04 Additional Estimates** | **Total** |
|---|---|---|---|
| Improved Medicare Affordability/Medicare Plus | 34.5 | 18.3 | 52.8 |
| A Focus on Prevention | 11.5 | 0.0 | 11.5 |
| National Illicit Drugs Strategy | 6.5 | 3.0 | 9.5 |
| Medical Indemnity | 0.0 | 8.4 | 8.4 |
| Improved PBS Concessional Validation | 2.0 | 0.0 | 2.0 |
| **Total 2003-04 Measures** | **54.5** | **29.7** | **84.2** |
| ASL variations flowing from previous financial years' Budget Measures | | | -6.1 |
| Net ASL Movement | | | 78.1 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-094OUTCOME: Whole of PortfolioTopic: INDIGENOUS STAFFING

Hansard Page: CA 126

Senator Moore asked:

Could you actually do some work on the rate of Indigenous employment in the department over the last five years at levels? I would really like to see the number of indigenous staff at each level in the department for the last five years.
Answer:

| | **30 June 2004** | **30 June 2003** | **30 June 2002** | **30 June 2001#** | **30 June 2000^** |
|---|---|---|---|---|---|
| Indigenous staff | 89* | 79* | 74* | - | - |
| Total percentage | 2.2% | 1.9% | 1.9% | 2.0% | - |

* Includes core department & TGA, numbers extracted from department's current HR system (SAP) and are of self identified staff.

# Total percentage data from the department's annual report. Indigenous staff numbers were not published in the department's annual report. The department's previous HR system NOMAD has now been archived and since the reporting facility is not available, data on Indigenous staff numbers cannot be provided.

^ Indigenous staffing data was not published in the department's 1999-2000 annual report due to problems in retrieving this information from the department's previous HR system NOMAD.

**Status of Indigenous Staff in the Department by Classification**

| **Classification** | **30 June 2004** | **30 June 2003** | **30 June 2002** |
|---|---|---|---|
| APS 1 | 2 | 3 | 2 |
| APS 2 | - | 1 | - |
| APS 3 | 9 | 5 | 10 |
| APS 4 | 9 | 6 | 6 |
| APS 5 | 24 | 21 | 15 |
| APS 6 | 21 | 18 | 18 |
| Executive Level 1 | 12 | 9 | 11 |
| Executive Level 2 | 3 | 4 | 3 |
| Public Affairs Officer Level 2 | 1 | - | - |
| Senior Executive Service 1 | 2 | 1 | 1 |
| Cadet | 5 | 10 | 6 |
| Trainee | 1 | 1 | 1 |
| Graduate APS | - | - | 1 |
| **TOTAL** | **89** | **79** | **74** |

It is not possible to provide the breakdown of the Indigenous staff in the department by classification prior to 30 June 2002 as the department's previous HR system NOMAD has been archived and the reporting facility is not available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-120

OUTCOME: Whole of Portfolio

Topic: DELAY IN TABLING 2003-04 DEPARTMENT OF HEALTH AND AGEING ANNUAL REPORT

Hansard Page: CA 124

Senator McLucas asked:

Who do you advise of these delays so that people know?

Answer:

Following several in-formal discussions, the Annual Report's project manager advised the Senate Tabling Office by telephone on 3 November 2004 that there would be a significant delay in tabling the Annual Report.

The Tabling Office response was to request they be given a few days notice in advance of the department presenting the Annual Report for tabling. This was done on 31 January 2005.

Attachment A

**Table 1: Total PHOFA Funding 2004-05 to 2008-09**

| State | Original Offer | Supplementary Funding | Current Agreement / offer |
|---|---|---|---|
| NSW | 244,705,158 | 13,326,036 | 258,031,194 |
| VIC | 194,516,122 | 2,612,134 | 197,128,256 |
| QLD | 155,223,797 | 0 | 155,223,797 |
| WA | 73,127,599 | 0 | 73,127,599 |
| SA | 60,362,916 | 1,977,902 | 62,340,818 |
| TAS | 27,735,072 | 1,211,458 | 28,946,530 |
| ACT | 15,345,605 | 1,978,769 | 17,324,374 |
| NT | 19,939,373 | 0 | 19,939,373 |
| TOTAL | 790,955,642 | 21,106,299 | 812,061,941 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-010

OUTCOME 1: Population Health and Safety

Topic: PREGNANCY COUNSELLING SERVICES

Written Question on Notice

Senator Stott Despoja asked:

(a) Can the government provide figures for the amount of funding provided to pregnancy counselling services in 2003-04, including direct and indirect funding? Please provide a breakdown of funding by organisation.

(b) Can the government provide figures for the amount of funding which will be allocated to pregnancy counselling services in the 2004-05 Budget, including direct and indirect funding? Please provide a breakdown of funding by organisation.

(c) Does the government have any information regarding which of these fully or partially publicly-funded pregnancy counselling services are pro-life and pro-choice?

Answer:

(a) The Australian Episcopal Conference of the Roman Catholic Church is funded to provide natural family planning counselling for the purpose of achieving or avoiding pregnancy. The Australian Federation of Pregnancy Support Services is funded to provide independent non-directive counselling for unplanned pregnancy. Family Planning Organisations funded under the national family planning program also provide independent non-directive counselling for unplanned pregnancy.

In 2003-04, the Australian Government provided direct funding of $900,810 to the Australian Episcopal Conference of the Roman Catholic Church.

In 2003-04, the Australian Government provided direct funding of $240,764 to the Australian Federation of Pregnancy Support Services.

In 2003-04 the following funding was received by family planning organisations:

| **Family Planning Organisations** | **2003-04 $** |
|---|---|
| FPA Health (NSW) | 4,986,371 |
| Family Planning Victoria | 2,557,079 |
| Family Planning Queensland | 2,868,564 |
| Family Planning Western Australia | 1,637,942 |
| Family Planning Tasmania | 535,851 |
| Family Planning Welfare Northern Territory | 443,302 |

The South Australian and the Australian Capital Territory Governments received funding for family planning via the Population Health Outcome Funding Agreements (PHOFAs). The level of funding allocated by the state or territory government for this purpose can not be disaggregated.

(b) The 2004-05 allocation for the Australian Episcopal Conference of the Roman Catholic Church is $918,826.

The 2004-05 allocation for the Australian Federation of Pregnancy Support Services is $245,580.

The Australian Government decided on 29 March 2004 that funding for all Family Planning Organisations would be incorporated within the Population Health Outcome Funding Agreements (PHOFAs) for the period 2004-05 to 2008-09. All states and territories have now signed the new agreements. The level of funding allocated by the state or territory government for this purpose can not be disaggregated. However, funding provided to support Family Planning Organisations by states and territories is expected to be at levels similar to the previous year.

(c) The objective of the Family Planning Program is to provide a balanced approach to differing family planning service models, aimed at promoting responsible sexual and reproductive behaviours, rather than focussing on one particular strategy or program. There are no requirements in the contracts with these organisations for them to declare whether or not they are pro-life or pro-choice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-011

OUTCOME 1: Population Health and Safety

Topic: PREGNANCY COUNSELLING SERVICES

Written Question on Notice

Senator Stott Despoja asked:

(a) Is the government aware of instances where pro-life organisations have purported to provide independent pregnancy counselling through emergency telephone listings?

(b) If so, does the government approve of this practice?

(c) If the government is aware of this practice but does not approve of it, will the government take action to ensure that organisations which do have such a bias are not represented as independent, through their name or otherwise?

Answer:

(a) The department is not aware of such instances.

(b) Not applicable.

(c) Family Planning Organisations funded under the National Family Planning Program provide independent non-directive counselling for unplanned pregnancy. Consumers are protected by the provisions of the *Trade Practices Act (1974)* which deals with misleading or deceptive conduct by a corporation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-012

OUTCOME 1: Population Health and Safety

Topic: IMPORTATION OF PREGNANCY TERMINATION DRUG

Written Question on Notice

Senator Troeth asked:

Australia is one of the few developed nations where women cannot get RU486 (also known as Mifepristone). RU486 has been available in Europe for 16 years, and was approved in the US in 2000. It is also recommended by the World Health Organisation. The drug has been proven to be an effective treatment regime for women requiring a termination of pregnancy and has been shown in many countries to not only be safe (and for some women the preferred method of termination) but to be more cost effective for individuals and national health care schemes. There is currently a legislative restriction in place in Australia that requires direct Ministerial and parliamentary approval of an application for importation of Mifepristone in Australia.

(a) Why is the restriction in place?

(b) Will the Minister further consider the use of this safe and effective drug so that it can be imported into Australia?

Answer:

(a) The *Therapeutic Goods Act 1989* was amended in June 1996, as a result of a proposal from Senator Harradine, to introduce a definition for, and procedures related to 'restricted goods' (Section 6AA and 23AA of the Act). 'Restricted goods' are defined as medicines (including progesterone anatagonists and vaccines against human chorionic gonadotrophin) intended for use in women as abortifacients. Under the amendments, the minister is responsible for approving the importation, evaluation or listing of any medicine intended for use in women as an abortifacient. The minister's written approval is required. Importation of abortifacients is also controlled under the Customs (Prohibited Imports) Regulations.

(b) Mifepristone (RU486) has never been approved for marketing in Australia by either the Therapeutic Goods Administration or its regulatory predecessor. For an abortifacient to be marketed in Australia, an application would need to be submitted with supporting data to demonstrate the quality, safety and effectiveness for the proposed use – the same as for any prescription drug. The government cannot compel a company to submit an application, nor can it approve a product in the absence of an application. In addition, written ministerial approval is required before a restricted good, such as RU486, may be evaluated for marketing approval. Ministerial approvals, including any conditions must be tabled before each House of the Parliament within five days of the approval being given. No application to register RU486 has been received in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-021

OUTCOME 1: Population Health and Safety

Topic: NATIONAL ILLICIT DRUG STRATEGY

Written Question on Notice

Senator Denman asked:

With reference to the answer to question E04-024, is any information available as to the work and findings to date of the cross jurisdictional working group to identify effectiveness measures for the life of the National Illicit Drug Strategy?

Answer:

An approach to evaluating and monitoring the National Drug Strategy is currently being developed in consultation with state and territory governments. It is expected that a finalised approach will be agreed to by all jurisdictions and available by the middle of the year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-022

OUTCOME 1: Population Health and Safety

Topic: NATIONAL TOBACCO STRATEGY

Written Question on Notice

Senator Denman asked:

With reference to the answer to question E04-031:

(a) Was the final draft of the National Tobacco Strategy presented to the MCDS in November 2004? If so, can a copy of it, or the final document, be made available?

(b) Have the new and emerging trends been identified as priority areas? Are they available?

(c) Has there been consideration of the proposed priority areas? If so, what were the outcomes? If not, by when is this expected to be done? If not, what is the reason that it has not yet been done?

Answer:

(a) Yes, the Ministerial Council on Drug Strategy endorsed the National Tobacco Strategy at its meeting on 12 November 2004. The National Tobacco Strategy is currently being desk-topped before being professionally printed. A final version of the strategy should be available in hardcopy and via the department's website shortly.

(b) The new National Tobacco Strategy 2004-2009 provides a broad policy framework for state and territory governments and the Australian Government. The strategy addresses a range of issues including further regulation of tobacco, improving services and treatment for smokers, tailoring smoke-free messages and undertaking more focused research and evaluation.

(c) As noted above, the new National Tobacco Strategy only provides a broad policy framework.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-023

OUTCOME 1: Population Health and Safety

Topic: CANNABIS USE

Written Question on Notice

Senator Denman asked:

I note that in the answer to question E04-037, the Department advised that it is not aware of any published data on the number of deaths in Australia that have been attributed solely or predominantly to cannabis use?

(a) Are there any reasons why the Department does not keep or has not sought to keep such data?
(b) Does this indicate a position that despite considerable cannabis usage (as indicated in the answer to question E04-036) that cannabis use is not considered to be a cause of death?

Answers:

(a) The department is reliant on mortality data predominantly provided by the Australian Bureau of Statistics (ABS) which is based on registered death certificates received from state and territory registrars of births, deaths and marriages. The ABS Information paper (2003) *Drug Induced Deaths 2001* provides some information about deaths attributed to drug use (excluding alcohol, tobacco and volatile substances) in Australia. However, there is no regularly published data on specific substance use related deaths.

(b) Internationally, causes of deaths are classified under the International Classification of Diseases and Related Health Problems (ICD-10), which are in turn determined by the World Health Organisation. ICD-10 classifications of death are attributed to the event leading directly to the death, rather than related causes such as drug use. Therefore, the ICD-10 does not always identify a specific drug as a 'cause' of death.

However, the department does recognise that all types of drug use, licit and illicit, are a significant factor in both mortality and morbidity throughout the Australian community.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-024

OUTCOME 1: Population Health and Safety

Topic: NATIONAL OBESITY TASKFORCE

Written Question on Notice

Senator Denman asked:

I refer to the answers given to questions E04-012 and 014: What is the current status of the implementation strategy for Healthy Weight 2008 – Australia's Future – The National Action Agenda for Children and Young People and Their Families? Has the draft been completed? Is a copy available? If not when is completion and availability expected?

Answer:

Healthy Weight 2008 has a strategic four year timeframe, acknowledging that a long term approach is required to address overweight and obesity. An initial set of actions commencing in 2004 has been approved by health ministers and announced in July 2004, that is:

- physical activity recommendations for children and youth;
- resource kits for schools to promote healthy eating and physical activity;
- a national information program to promote increased consumption of fruit and vegetables;
- the promotion of healthy school canteens;
- the establishment of a network of whole-of-community healthy weight demonstration sites; and
- a review of evidence for actions to reduce obesity in adults and older Australians.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-025

OUTCOME 1: Population Health and Safety

Topic: NATIONAL OBESITY TASKFORCE

Written Question on Notice

Senator Denman asked:

I refer to the answers given to questions E04-012 and 014:

(a) What is the current status of work on the review of the evidence for interventions, and the development of a framework to address overweight and obesity in adults and older Australians?

(b) Has the review been completed? Is a copy available?

(c) If not, when is completion and availability expected?

(d) If completed, what were the principle findings and recommendations of the review?

Answer:

(a) On 24 January 2005, the Department of Health and Ageing advertised RFT 10904/05, seeking proposals for a review of the evidence for interventions, and the development of a framework to address overweight and obesity in adults and older Australians. The tender period closed on Friday 25 February 2005. Proposals are currently being evaluated by a Tender Evaluation Committee.

(b) The review has not yet been completed, and is therefore not available.

(c) It is anticipated that the review will be completed and made available to the National Obesity Taskforce in late 2005. The report will then be presented to Australian Health Ministers Conference at their next meeting.

(d) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-026

OUTCOME 1: Population Health and Safety

Topic: NATIONAL OBESITY TASKFORCE - LIFESTYLE PRESCRIPTIONS

Written Question on Notice

Senator Denman asked:

I refer to the answers given to questions E04-012 and 014:

(a) What is the progress in relation to 'Lifestyle scripts'.
(b) What proportion of the $4.3 million has been expended to date?
(c) How has this been expended?
(d) What has been the uptake level by general practitioners?

Answer:

(a) In preparation for the national rollout of the Lifestyle Prescription initiative, the department has funded:
- the expansion of the Active Script program in Victoria; and
- the development, piloting and implementation of the Active Nutrition prescription.

Assessments of the Active Script program and the Active Nutrition pilot have shown that they have had a positive impact on GPs' ability to deliver advice on physical activity and nutrition to patients. The Active Script program has been shown to be a cost-effective intervention with patients increasing their physical activity. Both programs have been well received by GPs and patients alike.

Work is currently underway to develop lifestyle prescriptions for alcohol and smoking. The complete suite of tools and resources to integrate lifestyle prescriptions into general practice will be available in the second half of 2005.

(b) Of the $4.3 million, $1.7 million or 39% has been spent to date.

(c) These funds have been expended as follows:

| Item | Expenditure 2003-04 $ | Expenditure YTD 2004-05 $ |
|---|---|---|
| **Development of Lifestyle Prescription Resources**, eg scoping study, stakeholder workshop, dissemination of the Smoking, Nutrition, Alcohol, Physical Activity guidelines to GPs; trialling by Victoria Council on Fitness and General Health (VICFIT) of a physical activity/nutrition script; development of a resource guide for general practice by VICFIT and consortium partners | 276,200 | 266,950 |
| **Community Awareness raising activities**, eg Rural Health Education satellite broadcast; 'Walk to Work' sponsorship, promotional material | 429,611 | 47,726 |
| **Other resources** | 129,114 | 45,455 |
| Departmental expenses | 295,000 | 199,000 |
| Total | 1,129,925 | 559,131 |

(d) The uptake level by general practitioners will not be known until the Resource Kit has been disseminated and associated training has taken place.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2204-2005, 17 February 2005

Questions: E05-027

OUTCOME 1: Population Health and Safety

Topic: NATIONAL OBESITY TASKFORCE

Written Question on Notice

Senator Denman asked:

(a) Has the draft National Physical Activity for Health Action Plan been completed?

(b) Is a copy available?

(c) If not when is completion and availability expected?

Answer:

(a) The draft document, now titled *Be Active Australia: A Framework for Health Sector Action for Physical Activity 2005-2010*, is complete but not yet published.

(b) Be Active Australia has been circulated for comment as a draft but is not yet published.

(c) Be Active Australia was considered by the Australian Health Ministers Advisory Committee (AHMAC) on 2 March 2005. Further work is required and Be Active Australia will be presented again to the AHMAC on 16 June 2005. It is expected that Be Active Australia will be available following consideration by health ministers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Questions: E05-028

OUTCOME 1: Population Health and Safety

Topic: NATIONAL OBESITY TASKFORCE

Written Question on Notice

Senator Denman asked:

(d) Have dates been set for Walk to Work Day and Walk Safely to School Day for 2005?
(e) How will the Commonwealth's funding for these initiatives be expended in 2005?
(f) What steps is the Department taking to:
    (i) promote; and
    (ii) evaluate these initiatives?

Answer:

(a) Yes. Walk Safely to School Day will be held on 6 May 2005 and Walk to Work Day on 7 October 2005.

(b) The Commonwealth's funding will be expended through a funding agreement with the Pedestrian Council of Australia for the coordination, promotion and evaluation of the events.

(c)

(i) The department, through the funding agreement, requires the Pedestrian Council of Australia to promote the events.

The department also promotes the events through its regular contact with relevant state/territory committees, as well as organising activities in relation to Walk to Work Day for staff.

(ii) The funding agreement requires the Pedestrian Council of Australia to undertake an independent evaluation of each Walk to Work Day and Walk Safely to School Day event. The department will participate in a steering committee established to manage the overall evaluation of the project, for the period of the funding agreement (three years).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-029

OUTCOME 1: Population Health and Safety

Topic: HEALTHY WEIGHT BY 2008 - HEALTHY SCHOOL COMMUNITIES

Written Question on Notice

Senator Denman asked:

(a) In relation to the Healthy School Communities Program, how many grants have been made in each of the states and territories?

(b) Is the department happy with the uptake rate?

Answer:

(a) As at 1 March 2005, the department has paid 507 grants under the Healthy School Communities Program. A significant number of new applications are being received following the start of the new school year. The breakdown of the grants made to date by states and territories is as follows:

| | |
|---|---|
| NSW | 112 |
| NT | 17 |
| QLD | 85 |
| SA | 49 |
| TAS | 28 |
| VIC | 174 |
| WA | 38 |
| ACT | 4 |

(b) It is early in the new school year. The department is undertaking a number of steps as outlined under Question: E05-030 part (c), to promote the program, so that as many schools as possible will participate.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-030

OUTCOME 1: Population Health and Safety

Topic: HEALTHY WEIGHT BY 2008 - HEALTHY SCHOOL COMMUNITIES

Written Question on Notice

Senator Denman asked:

(a) I have heard from some schools in Tasmania that they do not believe they have received any communication about this program. What methods were used to promote its availability?

(b) Is there a cut off date for applications?

(c) Is there any plan to promote the scheme to school communities which have not yet made application? If not, why?

Answer:

(a) The following methods have been used to promote the Healthy School Communities Program:

- In July 2004, the Healthy School Communities information kit and application form was sent out to all school principals. The kit and application form are available on the website www.healthyactive.gov.au which was established for the Prime Minister's Building a Healthy Active Australia Initiative. To support the program, the department maintains an email address healthyschools@health.gov.au and has available a free call number 1800 805 172 which responds to any enquiries.

- At the national level, the department has promoted the program through members of the National Obesity Taskforce (NOTF) and the Strategic Inter-Governmental Nutrition Alliance (SIGNAL). The department also works closely with the Australian Sports Commission which has promoted the program in conjunction with the Active After-school Communities Initiative.

- At a local level, interested organisations have advertised the availability of the program within states and territories. In Tasmania, the initial promotion of the Healthy School Communities program was through Eat Well Tasmania (an initiative which identifies, supports and promotes opportunities for local business, government and non-government agencies, and community groups to form partnerships to promote enjoyable healthy eating).

(b) Yes. The cut off date for applications is 1 December 2005.

(c) Yes. The following activities are being undertaken to promote the scheme:

- During the first school term of 2005, the Minister for Health and Ageing, Tony Abbott, will send to all school principals in Australia two resource kits to promote physical activity and healthy eating. These kits contain Australia's Physical Activity Recommendations for Children and Young People, and information on best practice programs for promoting a healthy and active school community. In his letter, the Minister will remind principals that a grant of $1,500 (GST excl) is available until 1 December 2005, to support activities that encourage healthy eating.

- The department will follow up this letter by contacting the principals of all schools that have not yet applied for the grant during Term 1, to encourage them to take up the grant.

- The department will also send a letter to key organisations associated with schools to promote the Healthy School Communities grant in their newsletters. These organisations will include The Australian Parents' Council, Federation of Canteens in Schools, Australian Primary Principal's Association, Australian Secondary Principal's Association and the Australian Principal's Federation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-031

OUTCOME 1: Population Health and Safety

Topic: HEALTHY WEIGHT BY 2008 - HEALTHY EATING AND REGULAR PHYSICAL ACTIVITY

Written Question on Notice

Senator Denman asked:

(a) In relation to the Healthy Eating and Regular Physical Activity – Information for Australian Families program, how is this initiative being implemented?

(b) What is the current status of this initiative?

Answer:

(a) Healthy Eating

The department is developing a national information program to encourage healthy eating. The program will be based on the Go for 2 Fruit and 5 Veg campaign first screened in Western Australia.

It is anticipated that the healthy eating element of the information program will comprise national advertising and supporting print resources and will be underpinned by public relations activity.

A program of market research is guiding the development of the initiative to ensure that it meets the needs of Australian families in relation to information about healthy eating.

Physical Activity
The department is also developing a national information program to help parents encourage their children participate in regular physical activity, however, no final decision has been made on the creative concept.

It is anticipated that the physical activity element of the information program will comprise national advertising and supporting resources and will be underpinned by public relations activity.

Market research will guide the development of the initiative to ensure that it meets the needs of Australian families in relation to information about physical activity for children.

(c) Healthy Eating

This element of the information program is in the later stages of development with a current implementation target of April/May 2005.

Physical Activity
This element of the information program is in the early stages of development with a view to implementation in mid 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-032

OUTCOME 1: Population Health and Safety

Topic: HEALTHY WEIGHT BY 2008 - HEALTHY EATING AND REGULAR PHYSICAL ACTIVITY

Written Question on Notice

Senator Denman asked:

(d) What proportion of the $11 million allocated for this initiative has been expended to date?

(e) On what has this been spent?

Answer:

(a) $123, 177 (GST exclusive) of the $11 million has been expended to date.

With the Healthy Eating part of the information program now entering final development, expenditure will increase in the next few months to cover the production, testing and distribution costs of the national activity.

(b) Expenditure to 3 March 2005 is as follows:

- $71,215 to 303 Group (advertising agency) who are supplying creative development services for the Healthy Eating part of the information program;
- $51,782 to Woolcott Research for market research services for the Healthy Eating part of the information program; and
- $180.00 for ad hoc printing services.

TOTAL: $123, 177

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-033

OUTCOME 1: Population Health and Safety

Topic: HEALTHY WEIGHT BY 2008 - HEALTHY EATING AND REGULAR PHYSICAL ACTIVITY

Written Question on Notice

Senator Denman asked:

Have there been any delays in implementing the initiative as planned? If so, why?

Answer:

The Prime Minister announced the Building a Healthy, Active Australia initiative on 29 June 2004. The initiative includes a Healthy Eating and Physical Activity – Information Program for Australian Families.

**Healthy Eating**
Initial development work on the Healthy Eating element of the information program, including the engagement of the creative agency and research consultants, took place from June to August 2004. Work was suspended over the 2004 Federal Election period and recommenced in November 2004, with market testing of information concepts occurring in December 2004. The Healthy Eating part of the information program is now in the later stages of development with a targeted implementation date of April/May 2005.

**Physical Activity**
Licensing negotiations with the Australian Association of National Advertisers for the possible use of their 'Jo Lively' concept and the suspension of decisions regarding concept development over the 2004 Federal Election period, have delayed the progress of the Physical Activity part of the information program.

It is anticipated that this will be ready for implementation around the middle of 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-034

OUTCOME 1: Population Health and Safety

Topic: SEXUAL HEALTH, HIV/AIDS AND HEPATITIS C

Written Question on Notice

Senator Denman asked:

I refer to the answers to questions E04-055 and E04-060:

(a) Have the new National Hepatitis C and HIV/AIDS and Sexually Transmissible Infections strategies been finalised? If so, can a copy be made available? If not, why? When is it expected that they will be completed and available.

(b) Have new priority areas for action been identified as yet?

(c) What amendments have already been made or what amendments are envisaged to existing programmes?

(d) What new initiatives have been developed or are planned in response to the new priority areas for action?

(e) Did the new strategies take effect, as scheduled, on 1 January 2005? If not, why? When are they expected to take effect?

(f) At the time the last answer to me was prepared, the department indicated that the consultation process was still being devised. I assume that has since occurred. What was the process and who, and which organisations, were consulted during same?

Answer:

(a) The new National HIV/AIDS, Hepatitis C and Sexually Transmissible Infections (STIs) strategies are currently being finalised. The strategies are scheduled to take effect from 1 July 2005. The existing strategies were extended to enable more extensive consultation with key community groups. The strategies are currently in draft format and the finalised strategies are expected to be available closer to the date of implementation.

(b) Yes.

(c) No amendments have been made to existing programs. Implementation plans are yet to be finalised for each new strategy. Detailed consideration will be given to what amendments are required in this context.

(d) Initiatives and responses to the new priority areas for action identified in the new national strategies are currently in the preliminary stages of development. Details of these initiatives are expected to be available closer to the date of implementation.

(e) As outlined above, the strategies will take effect from 1 July 2005. The additional time has allowed for further consultation with key community groups.

(f) The process of consultation on the draft strategies has occurred in several stages. A period of public comment was held from 27 August to 29 October 2004. During this time all stakeholders, related peak bodies, state and territory governments and other Australian Government agencies were invited to provide submissions to the department on the draft strategies. National forums on the draft HIV/AIDS and Hepatitis C strategies were held on 16 and 17 November 2004, and attendees from a diverse range of stakeholder groups constructively discussed key issues arising from the submissions. These attendees were invited from all peak organisations; other key community based organisations; research centres and all states and territories. The strategies are currently being finalized, with advice from the Ministerial Advisory Committee on AIDS, Sexual Health and Hepatitis (MACASHH) and taking into account all issues raised in the consultation period.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-035

OUTCOME 1: Population Health and Safety

Topic: SEXUAL HEALTH, HIV/AIDS AND HEPATITIS C

Written Question on Notice

Senator Denman asked:

I refer to the answers to questions E04-055 and E04-060:
I note that it was intended that the new strategy would incorporate a broadening focus, for the first time on STIs. Has this occurred? Can the department advise how?

Answer:

The Australian Government is now developing a National STIs Strategy that is separate from the National HIV/AIDS Strategy. The separation of the two strategies was decided following consideration of the comments received on the draft National HIV/AIDS and STIs Strategy.

For the first time, there will be a separate national strategy in which STIs issues are addressed, apart from their role as a precursor and marker for HIV/AIDS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-036

OUTCOME 1: Population Health and Safety

Topic: SEXUAL HEALTH, HIV/AIDS AND HEPATITIS C

Written Question on Notice

Senator Denman asked:

I note that the department does not have any figures of the cost to the public purse of the failure to prevent or treat, at an early stage, sexually transmissible infections (STIs) other than HIV/AIDS and hepatitis C?

(a) Given the broadening focus on this area and the findings of the *Burden of Disease and Injury in Australia* report, why is this the case?

(b) Does the department have any intention of doing so now or in the future? If not, why?

Answer:

(a) This cost is difficult to ascertain for a number of reasons. Many early stage STIs are asymptomatic. Also significant complications of STIs, such as pelvic inflammatory disease, can be caused by a number of different diseases and conditions and as such it is often not possible to determine causality.

(b) The Australian Government is currently developing the new National STIs Strategy. Implementation of the strategy is scheduled to commence from 1 July 2005. Future research priorities, including the economic cost of asymptomatic STIs, are expected to be considered in the course of the strategy's implementation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-037

OUTCOME 1: Population Health and Safety

Topic: PUBLIC HEALTH OUTCOME FUNDING AGREEMENTS (PHOFAs) – SEXUAL HEALTH

Written Question on Notice

Senator Denman asked:

In the answer to question E04-064, it was stated that the new PHOFAs would include an agreed performance information framework (to ensure that under this new arrangement, the extent and quality of sexual and reproductive health services is maintained and guaranteed).

(a) Has this been developed?

(b) If so, can the details be provided?

(c) If not, by when is it expected that it will be available?

Answer:

(a) A set of outcome based performance indicators for broadbanded public health programs including sexual and reproductive health has been developed for inclusion in the new PHOFAs (2004 to 2009).

(b) The outcome based performance indicators for PHOFAs (2004-2009) are in the process of being finalised. The proposed indicators have been forwarded to states and territories for formal incorporation in the agreements. While some jurisdictions are still considering, others (New South Wales, Queensland, South Australia, Tasmania and the Northern Territory) have formally accepted the proposed indicators. Once the proposed performance indicators are accepted by all jurisdictions and incorporated in the agreements, they will be made available on the department's website.

(c) See answer to (b).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-038

OUTCOME 1: Population Health and Safety

Topic: CHLAMYDIA

Written Question on Notice

Senator Denman asked:

I refer to the answers given by the department to my questions E04-061 and E04-062.

I also refer to comments made by Dr Maree O'Sullivan, the Director of Sexual Health Services for Tasmania reported in the *Launceston Examiner* on 30 January 2005.

Both indicate alarming increases in the reported rate of the diagnosis of chlamydia.

(a) The Examiner report refers to Tasmanian figures for 2003 and 2004, whereas in the answer you provided to me, the last year was 2002. Does the department have any updated annual figures on (i) a national and (ii) state and territory basis on the reported incidence of chlamydia infections?

(b) Is the department concerned about the significant increases in the number of reported cases?

(c) On the department's figures on a national basis there seems to have been a 41% increase from 2000 to 2002. Has this caused the department to rethink its response to the disease?

(d) Given the department's view that undiagnosed and untreated chlamydia can lead to infertility, and the fact that we are already experiencing declining rates of infertility in this country, should we not be taking more active and aggressive measures to:
(i) educate target groups about the risks (ii) encourage reporting and treatment?

(e) Do the figures relating to chlamydia not justify a rethink of the direction indicated in answer E04-062 which indicates we are currently focussing on a general rather than a specific approach of sexual health education strategies?

Answer:

(a) The following table, based on data from the National Notifiable Diseases Surveillance System, provides this information.

**Number of notifications of chlamydia received from state and territory health authorities 1999-2004**

| Year | ACT | NSW | NT | QLD | SA | TAS | VIC | WA | Total |
|---|---|---|---|---|---|---|---|---|---|
| 1999 | 171 | 2374 | 821 | 4339 | 969 | 252 | 2951 | 1824 | 13701 |
| 2000 | 242 | 3559 | 1004 | 4816 | 1000 | 331 | 3257 | 2599 | 16808 |
| 2001 | 292 | 4293 | 1218 | 5444 | 1400 | 375 | 4110 | 2652 | 19784 |
| 2002 | 465 | 5744 | 1413 | 6446 | 1802 | 472 | 4974 | 3058 | 24374 |
| 2003 | 411 | 7689 | 1602 | 7661 | 1990 | 293 | 6453 | 3766 | 29895 |
| 2004 | 615 | 10174 | 730 | 9005 | 2438 | 663 | 7692 | 4379 | 35696 |

(b) The department recognises that chlamydia is an important public health issue. In recognition of this, it is expected that chlamydia is to be one of the three priority areas addressed in the new National Sexually Transmissible Infections (STIs) Strategy.

(c) The department does not have any data to infer if the size of the increase is due to increases in detection and reporting, actual increases in infections, or both. Such data is difficult to obtain.

(d) This issue is expected to be addressed in the context of implementation of the new National STIs Strategy.

(e) The new National STIs Strategy is expected to identify priority areas for action to address important STI issues, including chlamydia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-039

OUTCOME 1: Population Health and Safety

Topic: CHLAMYDIA

Written Question on Notice

Senator Denman asked:

You indicated in answer E04-062 that the new National HIV/AIDS and STI Strategy would be identifying priority areas for action to address chlamydia.

(a) Can you advise how this process is going?

(b) Have any areas of action yet been identified?

(c) Are there any specific plans in place at this time or envisaged for the period of the forward estimates?

Answer:

(a) The National Sexually Transmissible Infections (STIs) Strategy is now being developed separately from the new National HIV/AIDS Strategy. The STIs Strategy is currently being finalised with a scheduled implementation date of 1 July 2005. Priority action for addressing chlamydia is expected to be set out in this strategy.

(b) There are a number of areas for action identified in the draft National STIs Strategy however the strategy is not yet finalised.

(c) There are no specific plans in place at this time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-040

OUTCOME 1: Population Health and Safety

Topic: CHLAMYDIA

Written Question on Notice

Senator Denman asked:

I note Dr O'Sullivan's concern that there may be quite a high unreported incidence of Chlamydia amongst males, with the additional consequence that treated women have therefore a high chance of being re-exposed. I also suspect that there is a widespread perception out there in the community that Chlamydia is a disease that affects only women.

(d) Is the Department addressing these issues?
(e) Are there any strategies or programmes in place to educate men about the disease and encourage reporting and treatment?

Answer:

(a) Through development and implementation of the National STIs Strategy, the department expects to address chlamydia prevention, diagnosis and treatment. It is expected that this process will involve thorough examination of these issues with the intention of targeting those people most at risk of acquiring chlamydia. This analysis will consider a number of variables including gender.

(b) The Australian Government provides funding for activities which target gay and other homosexually active men for STI testing and prevention education, including chlamydia, in the context of HIV/AIDS. The government also provides funding for sexual health and HIV/AIDS prevention and treatment in Indigenous communities. This funding addresses STI issues, including chlamydia, in both Indigenous men and women.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-046

OUTCOME 1: Population Health and Safety

Topic: PARACETAMOL

Written Question on Notice

Senator Denman asked:

I refer to the answer to question E04-050. Whilst I appreciate that paracetamol is not an illicit substance, I am aware, as I am sure so is the department (given the answer to question 052), that it is used illicitly.

(a) Given that the TGA was sufficiently concerned to launch a campaign in 2003, why has the Department not attempted to obtain figures on the level of illicit use of paracetamol?

(b) Given the department's awareness of the Drug Action 2004 Report in Northern Tasmania which found that young Launceston people were overdosing on paracetamol more than on any other illicit drug, have you:
  (i) made any contact with the Tasmanian Government to discuss strategies or programmes to address the issue? If not, why?
  (ii) taken any action to address the issue through the department's own programmes and resources? If not, why?

(c) Has the department formed a view as to why this seems to be a particular problem in the Launceston area? If not, why?

(d) Is the TGA campaign about the safe and appropriate use of paracetamol still operating?

(e) Given the particular problem in Northern Tasmania, has any consideration been given to operating it there with special emphasis? If not, why?

(f) I note the department's answer that no funding has been allocated to address the paracetamol issue? What is the reason for not doing so?

Answer:

(a) Although the TGA's education campaign did not place a particular emphasis on paracetamol, information on the drug was included in the material about non-prescription analgesics. It arose from the findings of the Medicine Evaluation Committee's Review of Non- Prescription Analgesics.

Local misuse of a legal product, including paracetamol, is monitored by the State health authorities. Should this monitoring suggest evidence of a national trend of misuse, the Department would be able to discuss the issue in the Intergovernmental Committee on Drugs (IGCD) to consider appropriate responses. The states and territories are also able to raise issues in this forum.

There are very significant methodological challenges in attempting to measure localised or small scale activity. Population level surveys will not be effective.

(b) (i) The Launceston Drug Action Plan (LDAP) was produced with funding from the National Illicit Drug Strategy Community Partnerships Initiative. One of the key objectives identified in the LDAP final report is to establish policies and practices for reducing harm for young people who use drugs. The Drug Education Network, the Launceston City Council and the Tasmanian Government plan to operate a campaign in the next 6-12 months to address the dangers associated with licit drugs and over the counter drugs.

(ii) No, because the LDAP outlines the local strategies to be taken.

(c) The department has not formed a view as to why paracetamol overdose is a particular problem in the Launceston area. The data collected in relation to paracetamol overdose was obtained from the Accident and Emergency Department at the Launceston General Hospital. The LDAP is the first step to addressing the risks within the community by employing a whole of community approach. The issue is however a state/territory responsibility.

(d) The following information is still available on the TGA's website as part of information provided about analgesics: (refer www.tga.gov.au/npmeds/npmeds.htm#analgesics):

- Review of non-prescription analgesics: an update (2003)
- Review of non-prescription analgesics (1998)
- Paracetamol
- Guidelines released for safe use of paracetamol (media release, 2 Jun 2003)
- Information for consumers - paracetamol
- Practitioner fact sheet - paracetamol

In addition, better labelling of medicines containing paracetamol is being introduced.

(e) The TGA initiative was general in nature and covered all non-prescription analgesics, not just paracetamol. As such, the information has not been targeted at particular geographical regions.

(f) The issues raised in the LDAP relate not so much to illicit drugs as to the safe use of medicines and suicide prevention. The Australian Government has national strategies in place on both these issues.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-052

OUTCOME 1: Population Health and Safety

Topic: CONSUMER MEDICINES INFORMATION AND PRODUCE

Written Question on Notice

Senator Harradine asked:

Have any pharmaceuticals fallen under the new provisions for information in Consumer Medicine Information and Product Information on the use in pharmaceuticals of human embryos, human embryonic stem cells or any other material sourced from a human embryo or human embryonic stem cells? If so, please provide a copy of the CMI and the PI for each pharmaceutical.

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-053

OUTCOME 1: Population Health and Safety

Topic: ABORTION

Written Question on Notice

Senator Harradine asked:

I asked a question on notice to find what the department has done to determine the reasons women seek an abortion and how the department assists women with problems they encounter, so they have the option to avoid abortion. The department's response was that it had not been asked to prepare any reports on this issue.

Has the department suggested to the government that this would be an area worth exploring? If not, why not? Why not try to help women avoid an abortion?

Answer:

The question as to whether the department has suggested to the government that there should be research determining the reasons why women seek an abortion seeks information about whether certain policy advice was provided to government by the department. The department is therefore unable to provide a response.

In 2004-05 the Australian Government has committed to provide funding of $16.78 million to a range of sexual and reproductive health services under the Family Planning Program. This comprises $15.4 million through the Public Health Outcome Funding Agreements between the Commonwealth and individual states and territories and $1.378 million to non-government organisations.

The objective of the Family Planning Program is to provide a balanced approach to differing family planning service models, aimed at promoting responsible sexual and reproductive behaviours, rather than focussing on one particular strategy or program. This aims to increase choices for women who wish to seek advice from different perspectives.

The Family Planning Organisations and the Australian Federation of Pregnancy Support Services, funded by the Australian Government, provide independent non-directive counselling for unplanned pregnancy. This includes assisting women to review options available to them in the light of their own circumstances and assisting and referring them for support when they wish to avoid abortion.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-054

OUTCOME 1: Population Health and Safety

Topic: PUBLIC HEALTH OUTCOME FUNDING AGREEMENTS

Written Question on Notice

Senator Harradine asked:

In response to a question without notice earlier this month, Senator Patterson representing the Minister for Health said "We do fund the states through the Public Healthcare Outcome Agreements to run programs to give advice and assistance to people who are facing unwanted pregnancies. The states administer those. In the last agreement that was to the tune of $70 million".

(a) Would you please provide me with details of how that $70 million is to be spent?

(b) How does this money assist women who are pregnant in difficult circumstances to overcome the difficulties they face?

Answer:

(a) The Australian Government provided some $70 million over the last five years (1999-2004) to the National Family Planning Program for sexual and reproductive health. During this period, two jurisdictions (South Australia and the Australian Capital Territory) received funding for Family Planning Organisations through the second round of Public Health Outcome Funding Agreements (PHOFAs), and the remaining jurisdictions (New South Wales, Victoria, Western Australia, Tasmania and the Northern Territory) through direct contractual funding arrangements between the Australian Government and Family Planning Organisations. Funding for Family Planning services for all jurisdictions is now provided through the new PHOFAs (2004-2009). The new PHOFAs (2004-2009) provide a total of $812 million over five years in pooled funding for a range of public health programs including sexual and reproductive health.

(b) Family Planning Organisations build the capacity of the health care sector by providing specialist sexual and reproductive health education and clinical training to health and other professionals. As a basis for training health and other professionals Family Planning Organisations also offer targeted clinical, education and counselling to high need population groups. One of the services which Family Planning Organisations provide is independent, non-directive counselling for unplanned pregnancy. The PHOFAs ensure that such services are provided through the inclusion of specific performance indicators against which jurisdictions are required to report. The PHOFAs (2004-2009) contain performance indicators for the provision of sexual and reproductive health, including providing "counselling and advice on the full range of options". Options are defined to include, "for example, pregnancy support, advice on the viability of single parenthood and adoption".

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-055

OUTCOME 1: Population Health and Safety

Topic: SEXUAL AND REPRODUCTIVE HEALTH SERVICES

Written Question on Notice

Senator Harradine asked:

In answer to E04-039 (b), the department stated the government provided $16.4 million to "a range of sexual and reproductive health services."

(a) Please provide a breakdown of funding to each particular service, the name of the service and what it provides.

(b) Is funding dependent on certain outcomes/benchmarks being met?

(c) If so, what are these outcomes?

Answer:

(a) In 2003-04, the Australian Government provided $16.4 million to a range of sexual and reproductive health services. Below is a listing of services:

| | **2003-04 $** |
|---|---|
| FPA Health (NSW) | 4,986,371 |
| Family Planning Victoria | 2,557,079 |
| Family Planning Queensland | 2,868,564 |
| Family Planning Western Australia | 1,637,942 |
| Family Planning Tasmania | 535,851 |
| Family Planning Welfare Northern Territory | 443,302 |
| Sexual Health and Family Planning Australia (national peak body) | 98,201 |
| Working Women's Health | 111,635 |
| Australian Episcopal Conference of the Roman Catholic Church | 900,810 |
| Australian Federation of Pregnancy Support Services | 240,764 |

The South Australian and the Australian Capital Territory Governments received funding for family planning via the Population Health Outcome Funding Agreements (PHOFAs). The level of funding allocated by the state or territory government for this purpose can not be disaggregated.

Following is an indication of what each service provides:

*Family Planning Organisations* are funded to build the capacity of the health care sector by providing specialist sexual and reproductive health education and clinical training to health and other professionals. As a basis for training health and other professionals Family Planning Organisations also offer targeted clinical, education and counselling to high need population groups.

*Sexual Health and Family Planning Australia Inc (SHFPA)* is funded to act as a national peak body for the Family Planning Organisations. SHFPA provides the Australian Government and Family Planning Organisations with information and advice on the current and future trends affecting sexual and reproductive health.

*The Australian Episcopal Conference of the Roman Catholic Church* is funded to provide vocational training and education to health and other professionals as well as sexual and reproductive health and education services to high need population groups, such as older women in their reproductive health years, young people, regional and rural Australians, Aboriginal and Torres Strait Islander peoples and people with a disability. They also provide information about natural family planning methods.

*Working Women's Health* is funded to provide culturally appropriate sexual and reproductive health training to bilingual community and health educators as well as sexual and reproductive education services to newly arrived or isolated women from diverse cultures in the workplace.

*The Australian Federation of Pregnancy Support Services* is funded to provide support for women experiencing difficulties with their pregnancy. They also provide sexual health counselling services for women requiring support for an unplanned pregnancy, vocational training and education for counsellors in pregnancy support services and community outreach, for high need population groups.

(b) The department has funding agreements with all four national organisations funded through the national family planning program. Funding agreements are managed within a quality framework and organisations are responsible and accountable for the delivery of agreed outputs. Such outputs vary between organisations; they include accredited training, national consistency, service standards, national partnerships and reporting of statistical data. Performance against these outputs is evaluated and measured through an agreed project plan and associated forecast expenditure plan. Organisations are required to report six monthly and these progress reports are linked to payments. Progress reports must include analysis of progress against the project plan, as well as financial statements.

The Public Health Outcome Funding Agreements contain performance indicators for the provision of sexual and reproductive health, including providing "counselling and advice on the full range of options". Options are defined to include, "for example, pregnancy support, advice on the viability of single parenthood and adoption".

(c) Key Outputs for Family Planning Organisations included:

- Contribute to the development of knowledge, skills and attitudes of health and other professionals in the areas of women's and men's sexual and reproductive health.
- Provide high quality specialised clinical services as a base for the training of health professionals.
- Promote sexual and reproductive health, through health promotion programs,

including information and education, to the general community, with particular focus on people who are members of socially and economically disadvantaged groups and people resident in regional and rural Australia.

Key Outputs for Sexual Health and Family Planning Australia Inc included:

- Support and facilitate Family Planning Organisations to develop knowledge, skills and attitudes in health and other professionals in the areas of women's and men's sexual and reproductive health.
- Support and facilitate Family Planning Organisations in their provision of high quality specialised clinical services as a base for the training of health professionals.
- Support and facilitate the Family Planning Organisations to provide sexual and reproductive health through health promotion programs, information and education to the general community, with a particular focus on the needs of those who experience socio-economic disadvantage and those who live in regional and rural Australia.

Key Outputs for the Australian Episcopal Conference of the Roman Catholic Church included:

- Provide services in natural family planning methods to the Australian Community.
- Develop and enhance partnerships and linkages with other organisations providing similar and related services, which can complement the work of the Australian Episcopal Conference of the Roman Catholic Church.

Key Outputs for Working Women's Health included:

- Provide community outreach to women from culturally diverse communities in health promotion relating to sexual and reproductive health.
- Provide culturally appropriate training to bilingual health educators, health professionals and other workers.
- Develop and update publications about sexual and reproductive health.

Key Outputs for the Australian Federation of Pregnancy Support Services included:

- Provide effective pregnancy support services and community outreach.
- Accredit trained counsellors in affiliated agencies.

Performance against these outputs is measured through an agreed project plan and associated reporting mechanisms.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-056

OUTCOME 1: Population Health and Safety

Topic: PREGNANCY SUPPORT SERVICES

Written Question on Notice

Senator Harradine asked:

In answer to E04-039, the department says that it funds services for counselling, support and advice concerning pregnancy.

(a) How many services does the department fund which provide practical assistance to women to address factors that might otherwise drive them to an abortion?

(b) What are the names of those services?

(c) What is their annual funding?

Answer:

(a) The Australian Government funds nine services which provide counselling for unplanned pregnancy. These services are funded either through the Public Health Outcome Funding Agreements or directly by the department.

(b)

Australian Federation of Pregnancy Support Services
FPA Health (NSW)
Family Planning Victoria
Family Planning Queensland
FPWA (formally Family Planning WA)
Family Planning Tasmania
Family Planning Welfare Association of the NT Inc
Sexual Health Information, Networking and Education South Australia
Sexual Health and Family Planning ACT

(c) The 2004-05 allocation for the Australian Federation of Pregnancy Support Services is $245,580.

The Australian Government decided on 29 March 2004 that funding for all Family Planning Organisations would be incorporated within the Population Health Outcome Funding Agreements (PHOFAs) for the period 2004-05 to 2008-09. All states and territories have now signed the new agreements. The level of funding allocated by the state or territory government for this purpose can not be disaggregated. However, funding provided to support Family Planning Organisations by states and territories is expected to be at levels similar to the previous year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-057

OUTCOME 1: Population Health and Safety

Topic: FAMILY PLANNING AND PREGNANCY COUNSELLING

Written Question on Notice

Senator Harradine asked:

I note from earlier answers that the department provides $13 million annually to family planning organisations - organisations which are major referrers to abortion clinics - and less than $250,000 annually to a pregnancy counselling agency which provide support to women so they can avoid abortion if they wish. Isn't this a major disparity?

Answer:

The objective of the Family Planning Program is to provide a balanced approach to differing family planning service models, aimed at promoting responsible sexual and reproductive behaviours, rather than focussing on one particular strategy or program. This aims to increase choices for women who wish to seek advice from different perspectives.

The Family Planning Organisations and the Australian Federation of Pregnancy Support Services, funded by the Australian Government, provide independent, non-directive counselling for unplanned pregnancy. This includes assisting women to review options available to them in the light of their own circumstances and assisting and referring them for support when they wish to avoid abortion.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-058

OUTCOME 1: Population Health and Safety

Topic: PREGNANCY

Written Question on Notice

Senator Harradine asked:

Is the department aware of the strong relationship between mental health, unemployment, poverty and sole parenthood?

What is it doing, in cooperation with other government departments, to address these factors so that fewer women will be put in the position of facing a pregnancy under difficult circumstances?

Answer:

This matter does not lie solely in the domain of the Department of Health and Ageing. The department provides support through Medicare for a range of health services that while universally available to all, target people who are in difficult circumstances.

One of the key components of the Australian Government funded Family Planning Organisations is the provision of sex education, predominately to groups who would not usually access mainstream health services including: migrant populations; homeless; young people; and people with a disability.

The Australian Government also has established the Maternity Payment, which is a one off payment to help with the extra costs of a new baby. Babies must be born or adopted on or after 1 July 2004. The payment is paid as a lump sum, of $3,000 for each new born child. The payment will increase to $4,000 from 1 July 2006 and increase again to $5,000 from 1 July 2008. In addition, a Parenting Payment is also available and can be made to both sole and partnered parents with a qualifying child under 16 and on meeting defined eligibility requirements.

The Australian Government is aware that both international and Australian research demonstrates a strong relationship between social and economic participation and individual health outcomes.

However, many of the causes of poor health outcomes sit outside the health system. Ensuring a good average level of health in the population therefore requires a socially and economically healthy country as well as a strong health system. The government has in place policies aimed at promoting strong economic growth, employment and education outcomes, and ensuring better standards of living for all Australians.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-060

OUTCOME 1: Population Health and Safety

Topic: MORNING AFTER PILL - ADVERSE REACTIONS

Written Question on Notice

Senator Harradine asked:

(a) Has the Adverse Drugs Reactions Advisory Committee received any notifications regarding the Morning After Pill? If so, how many?

(b) How many of these were supplied over the counter?

Answer:

(a) The committee has received 20 notifications of suspected adverse drug reactions to Postinor-2 a product used as a Morning After Pill.

(b) Since the Morning After Pill (Postinor-2) was made available over-the-counter on 1 January 2004 the committee has received six suspected adverse drug reaction reports. In one of these reports it is explicitly stated that the product was 'prescribed' by a gynaecologist. None of the other five reports stated whether the product had been prescribed or purchased over-the-counter.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-062

OUTCOME 1: Population Health and Safety

Topic: SEXUALLY TRANSMITTED INFECTIONS

Written Question on Notice

Senator Harradine asked:

Has the department commissioned any research into the disturbing rise of sexually transmitted infections in Australia? Please provide a copy.

Answer:

The department has not commissioned any specific research on the rises in sexually transmissible infections. The department coordinates surveillance of sexually transmissible infections through the National Notifiable Diseases Surveillance System (NNDSS) (http://www1.health.gov.au/cda/Source/CDA-index.cfm). The NNDSS serves as the basis of the quarterly publication *Communicable Diseases Intelligence*, which provides current analysis and expert commentary on communicable diseases in Australia (copy attached).

The report may be accessed at:
http://www.health.gov.au/internet/wcms/publishing.nsf/Content/cda-pubs-2004-cdi2801-pdf-cnt.htm/$FILE/cdi2801.pdf

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-063

OUTCOME 1: Population Health and Safety

Topic: SEXUALLY TRANSMITTED INFECTIONS (STIs)

Written Question on Notice

Senator Harradine asked:

(a) Please provide a table showing a breakdown by STI indicating the incidence in each state and territory.

(b) How much do STIs cost the health budget?

(c) Does the department provide funding for education programs on STIs? If so, please provide details for each of the programs and the amounts of funding for each?

Answer:

(a) The following table, based on data from the National Notifiable Diseases Surveillance System, provides this information.

**Notification of selected diseases received from state and territory health authorities for the period January to December 2004**

| **Sexually Transmissible Infection** | **ACT** | **NSW** | **NT** | **QLD** | **SA** | **TAS** | **VIC** | **WA** | **Total** |
|---|---|---|---|---|---|---|---|---|---|
| Chlamydia | 625 | 9982 | 1638 | 8909 | 2419 | 671 | 7559 | 4302 | 36105 |
| Donovanosis | 0 | 0 | 5 | 2 | 0 | 0 | 0 | 2 | 9 |
| Gonococcal infection | 35 | 1445 | 1587 | 1202 | 377 | 30 | 1125 | 1419 | 7220 |
| Syphilis | 15 | 1 | 137 | 0 | 15 | 0 | 0 | 0 | 168 |
| Syphilis < 2 years | 4 | 295 | 56 | 101 | 8 | 2 | 87 | 49 | 602 |
| Syphilis > 2 years or unknown | 8 | 1152 | 104 | 195 | 1 | 11 | 328 | 157 | 1956 |
| Syphilis Congenital | 0 | 0 | 6 | 3 | 0 | 0 | 1 | 0 | 10 |

NB: From 2002 the case definition for syphilis under the National Notifiable Diseases Surveillance System was broken down into 'syphilis - infectious, less than 2 years' and 'syphilis - more than 2 years or unknown'. From 2004 jurisdictions were required to report syphilis notifications according to these new case definitions. Not all jurisdictions have yet modified their reporting and thus in 2004 syphilis was reported upon using all three case definitions.

The table below presents national HIV/AIDS data for 2003. Data for 2004 is not yet available as additional analysis of HIV/AIDS data is routinely conducted to adjust for multiple reporting.

**Cases of newly diagnosed HIV infection in 2003 adjusted for multiple reporting by State and Territory**

| | Male | Female |
|---|---|---|
| **ACT** | 3 | 1 |
| **NSW** | 354 | 30 |
| **NT** | 4 | 1 |
| **QLD** | 112 | 17 |
| **SA** | 40 | 2 |
| **TAS** | 0 | 0 |
| **VIC** | 185 | 17 |
| **WA** | 33 | 11 |
| **TOTAL** | **782** | |

NB: Numbers do not sum to total as a result of diagnoses in people whose sex was reported as transgender and diagnoses in more than one state/territory.

(b) This figure is not able to be accurately calculated.

(c) The department provides annual funding to the Australian Federation of AIDS Organisations (AFAO) for a national HIV/AIDS education program. In 2004-05, AFAO is receiving $1,073,572 for this activity. In addition, the department is providing the Multicultural HIV/AIDS and Hepatitis C Service $55,297 for the National Positive Diversity Project. This project commenced on 1 July 2002 to address the information and education needs of people living with HIV/AIDS from culturally and linguistically diverse backgrounds.

The department, through the Office for Aboriginal and Torres Strait Islander Health, delivers approximately $280 million annually to enhance access to, and increase the range of comprehensive primary health care services for Aboriginal and Torres Strait Islander People, including sexual health and HIV/AIDS prevention and treatment services. Within this allocation, $9.6 million will directly target provision of services for sexual health and HIV/AIDS prevention and treatment in Indigenous communities in 2004-05. These activities include providing education about STIs.

The department also provides some $15 million per annum to support the work of state and territory Family Planning Organisations. These organisations provide a wide range of services relating to sexual and reproductive health including education programs on STIs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-064

OUTCOME 1: Population Health and Safety

Topic: SEXUAL HEALTH EDUCATION

Written Question on Notice

Senator Harradine asked:

(a) What evidence does the department have of the success of sex education in reducing the number of abortions in Australia?

(b) Is it possible to prove sex education has an impact on the abortion rate, when the only evidence you will have is whether there is a reduction in the number of teenage mothers?

(c) Does the department agree that a reduction in the number of teenage mothers could indicate a higher abortion rate?

Answer:

(a) There has been a preliminary literature review by the department on the subject of sex education and its relationship to termination of pregnancy. The literature review, which is current as at 10 March 2005, indicates that comprehensive sex education, primarily focused at young people, is associated with delay of sexual activity and reduction in high risk sexual behaviour (eg. unprotected sex). References at Attachment A.

The department is also aware of research which suggests that the majority of unplanned pregnancies are likely to be attributable to contraceptive method failure or inconsistent use.

(b) The literature review suggests that an important way of reducing unwanted pregnancy is through appropriate sex education programs, as this allows for young people to make more informed choices about the consequences of their actions and to make considered decisions about relying more on contraception and delaying the commencement of sexual activity.

The department is unaware of any clear evidence that a reduction in the number of teenage mothers could indicate a higher abortion rate. However, the department is aware that both the fertility rate and the number of abortions among females aged 15-19 years have decreased.

The Australian Bureau of Statistics (ABS) has reported that the teenage fertility rate (the number of births in a given year per 1,000 females aged 15-19 years) has been declining since the 1970s. The rate of childbearing among Australian teenage girls peaked at 55.5 births per 1,000 females in 1971 and has been steadily falling to its lowest rate of 16.3 births per 1,000 females in 2003.

In addition, the estimated number of termination procedures performed on women aged between 15 and 19 years has decreased from about 16,200 in 1994-95[#] to about 15,100 in 2003-04[#] ^

Taken together, falling rates of both child bearing and termination procedures would indicate that there is a greater usage of contraception and/or greater abstinence in this age group.

[#]Source: National Morbidity Data Set and MBS out of hospital data.

^ Excludes terminations after 20 weeks of gestation conducted in Victoria due to concerns expressed by the Department of Human Services regarding accuracy of the data in that year.

**Attachment A**

**References for Preliminary Literature Search and Review on the Effects of Education on the Termination of Pregnancy**


Alouini, S., Uzan, M., Meningaud, J. P., & Herve, C. **'Knowledge about contraception in women undergoing repeat voluntary abortions, and means of prevention'**, *European Journal of Obstetrics, Gynecology, & Reproductive Biology*, vol. 104, no. 1, 5 Aug 2002. pp. 43-48.

Benagiano, G. & Pera, A. **'Decreasing the need for abortion: challenges and constraints'**, *International Journal of Gynecology & Obstetrics*, vol. 70, no. 1, Jul 2000. pp. 35-48.

Breitbart, V. **'Counseling for medical abortion'**, *American Journal of Obstetrics & Gynecology*, vol. 183, no. 2 Suppl, Aug 2000. pp. S26-S33.

Bugden, P. **'30 years of helping women with unplanned pregnancies'**, *Catholic Leader* no. 10, Aug 2003, 10 Aug 2003. pp. 9.

Collins, B. **'Consistent or conflicting? Sexual health legislation and young people's rights in New Zealand'**, *Social Policy Journal of New Zealand*, vol. 15, Dec 2000. pp. 1-10.

Dale, P. 'Counseling **for teenager's pregnancy resolutions: broadening normative influences'**, *Relatewell*, vol. 6, no. 2, Jun 2002. pp. 5-7.

Darroch, J. E. **'Adolescent pregnancy trends and demographics'**, *Current Women's Health* Reports, vol. 1, no. 2, Oct 2001. pp. 102-110.

Jones, R. K., Darroch, J. E., & Henshaw, S. K. **'Contraceptive use among U.S. women having abortions in 2000-2001'**, *Perspectives on Sexual & Reproductive Health*, vol. 34, no. 6, Nov 2002. pp. 294-303.

Kumar, U., Baraitser, P., Morton, S., & Massil, H. **'Peri-abortion contraception: a qualitative study of users' experiences'**, *Journal of Family Planning & Reproductive Health Care*, vol. 30, no. 1, Jan 2004. pp. 55-56.

Lastman, A. **'Sex education and the young'**, *Australian Family*, vol. 23, no. 3, Nov 2002. pp. 42-45.

Ludmer, P. I., Nucci-Sack, A., & Diaz, A. **'Adolescent abortion: trends and techniques'**, *Current Women's Health Reports*, vol. 3, no. 6, Dec 2003. pp. 438-444.

Mazza, D. 'Family **planning all about choices'**, *Australian Doctor* 19 Jan 2001. pp. 33-34.

Mogensen, K. 'Personal **space'**, *Australian Educator* no. 43, 2004. pp. 24-29.

Rotondi, M., Labriola, D., Ammaturo, F. P., Perone, C., Manzo, E., Magliole, A., Rampone, N., & Panariello, S. '**Induced abortion and contraception: survey of 576 young women in Naples**', *Clinical & Experimental Obstetrics & Gynaecology*, vol. 27, no. 1, 2000. pp. 47-50.

Skinner, S. R. & Hickey, M. '**Current priorities for adolescent sexual and reproductive health in Australia**', *Medical Journal of Australia*, vol. 179, no. 3, Aug 2003. pp. 158-161.

Williams, H. & Davidson, S. '**Improving adolescent sexual and reproductive health. A view from Australia: learning from world's best practice**', *Sexual Health*, vol. 1, no. 2, 2004. pp. 95-105.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-065

OUTCOME 1: Population Health and Safety

Topic: FAMILY PLANNING SERVICES

Written Question on Notice

Senator Harradine asked:

According to the University of Nottingham's Professor David Paton, who published a paper on this in the *Journal of Health Economics in 2002*, there is no evidence that the provision of family planning reduces either under age conception or abortion rates. According to Professor Paton, the evidence indicates that family planning services expand the problem among younger teens and that there was an increased incidence of sexually transmitted infection.

(a) What evidence does the department have that family planning reduces the abortion rate?

Answer:

(a) One of the key components of the Australian Government funded Family Planning Organisations is the provision of sex education, predominately to groups who would not usually access mainstream health services including: migrant populations; homeless; young people; and people with a disability.

There has been a preliminary literature review by the department on the subject of sex education and its relationship to termination of pregnancy. The literature review, which is current as at 10 March 2005, indicates that comprehensive sex education, primarily focused at young people, is associated with delay of sexual activity and reduction in high risk sexual behaviour (eg. unprotected sex). References at Attachment A.

The literature review suggests that an important way of reducing unwanted pregnancy is through appropriate sex education programs, as this allows for young people to make more informed choices about the consequences of their actions.

The department is aware of research which suggests that the majority of unplanned pregnancies are likely to be attributable to contraceptive method failure or inconsistent use.

The department is aware that both the fertility rate and the number of abortions among females aged 15-19 years have decreased.

The Australian Bureau of Statistics (ABS) has reported that the teenage fertility rate (the

number of births in a given year per 1,000 females aged 15-19 years) has been declining since the 1970s. The rate of childbearing among Australian teenage girls peaked at 55.5 births per 1,000 females in 1971 and has been steadily falling to its lowest rate of 16.3 births per 1,000 females in 2003.

In addition, the estimated number of termination procedures performed on women aged between 15 and 19 years has decreased from about 16,200 in 1994-95[#] to about 15,100 in 2003-04[#] ^

Taken together, falling rates of both child bearing and termination procedures would indicate that there is a greater usage of contraception and/or greater abstinence in this age group.

[#]Source: National Morbidity Data Set and MBS out of hospital data.

^ Excludes terminations after 20 weeks of gestation conducted in Victoria due to concerns expressed by the Department of Human Services regarding accuracy of the data in that year.

**Attachment A**

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Breitbart, V. **'Counseling for medical abortion'**, *American Journal of Obstetrics & Gynecology*, vol. 183, no. 2 Suppl, Aug 2000. pp. S26-S33.

Bugden, P. **'30 years of helping women with unplanned pregnancies'**, *Catholic Leader* no. 10, Aug 2003, 10 Aug 2003. pp. 9.

Collins, B. **'Consistent or conflicting? Sexual health legislation and young people's rights in New Zealand'**, *Social Policy Journal of New Zealand*, vol. 15, Dec 2000. pp. 1-10.

Dale, P. 'Counseling **for teenager's pregnancy resolutions: broadening normative influences'**, *Relatewell*, vol. 6, no. 2, Jun 2002. pp. 5-7.

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Jones, R. K., Darroch, J. E., & Henshaw, S. K. **'Contraceptive use among U.S. women having abortions in 2000-2001'**, *Perspectives on Sexual & Reproductive Health*, vol. 34, no. 6, Nov 2002. pp. 294-303.

Kumar, U., Baraitser, P., Morton, S., & Massil, H. **'Peri-abortion contraception: a qualitative study of users' experiences'**, *Journal of Family Planning & Reproductive Health Care*, vol. 30, no. 1, Jan 2004. pp. 55-56.

Lastman, A. **'Sex education and the young'**, *Australian Family*, vol. 23, no. 3, Nov 2002. pp. 42-45.

Ludmer, P. I., Nucci-Sack, A., & Diaz, A. **'Adolescent abortion: trends and techniques'**, *Current Women's Health Reports*, vol. 3, no. 6, Dec 2003. pp. 438-444.

Mazza, D. 'Family **planning all about choices'**, *Australian Doctor* 19 Jan 2001. pp. 33-34.

Mogensen, K. 'Personal **space'**, *Australian Educator* no. 43, 2004. pp. 24-29.

Rotondi, M., Labriola, D., Ammaturo, F. P., Perone, C., Manzo, E., Magliole, A., Rampone, N., & Panariello, S. '**Induced abortion and contraception: survey of 576 young women in Naples**', *Clinical & Experimental Obstetrics & Gynaecology*, vol. 27, no. 1, 2000. pp. 47-50.

Skinner, S. R. & Hickey, M. '**Current priorities for adolescent sexual and reproductive health in Australia**', *Medical Journal of Australia*, vol. 179, no. 3, Aug 2003. pp. 158-161.

Williams, H. & Davidson, S. '**Improving adolescent sexual and reproductive health. A view from Australia: learning from world's best practice**', *Sexual Health*, vol. 1, no. 2, 2004. pp. 95-105.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-066

OUTCOME 1: Population Health and Safety

Topic: SEX EDUCATION

Written Question on Notice

Senator Harradine asked:

What funding does the department provide to support sex education programs which advocate abstinence as the only guaranteed way of avoiding pregnancy as well as a range of health-related problems like sexually transmitted disease?

Answer:

The department does not provide ongoing funding for sex education programs, other than that provided through the national Family Planning Program which aims to provide a philosophically balanced approach to differing family planning service models.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-116

OUTCOME 1: Population Health and Safety

Topic: ATAGI RECOMMENDATIONS ON VACCINES

Written Question on Notice

Senator McLucas asked:

What resources does the department provide to ATAGI for its ongoing assistance in providing updated information to the department and the Minister?

Answer:

The department supports the ATAGI Secretariat and Working Party Secretariats, and provides additional funds as required for specific research projects commissioned by ATAGI. In addition, the department is providing $2.8 million over four years to the National Centre for Immunisation Research and Surveillance of Vaccine Preventable Diseases (NCIRS). NCIRS undertakes many research tasks on vaccine issues as requested by ATAGI and approved by the department.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-166

OUTCOME 1: Population Health and Safety

Topic: ATAGI RECOMMENDATIONS ON VACCINES

Written Question on Notice

Senator McLucas asked:

How much has the total annual cost to government of oral polio vaccine increased over the 12 months, ending January 2005?

(a) How much is this cost, and increase in cost, per unit of polio vaccine?
(b) How much would it now cost annually to shift to injected polio vaccine?

Answer:

The total cost of oral polio vaccine has not increased in the 12 months ending January 2005.

(a) There is no increase per unit of polio vaccine.

(b) The Minister for Health and Ageing announced on 7 March 2005 that the government is funding the replacement of oral polio vaccine with injectable inactivated polio vaccine from 1 November 2005. This has been costed at an additional net cost of $63.3 million over four years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-167

OUTCOME 1: Population Health and Safety

Topic: ATAGI RECOMMENDATIONS ON VACCINES

Written Question on Notice

Senator McLucas asked:

Does this estimate include the savings that would result from fewer vaccination shots (arising from a combination vaccine)?

(a) Has the department costed the savings (both in immunisation and medicare/GP visits) which would arise from the use of a combination vaccine?

(b) What is the department's estimate of this saving?

Answer:

(a) and (b)
While there are other benefits from combination vaccines, there is no reduction in administrative costs to the Australian Government associated with moving to inactivated polio vaccine combinations, because the number of general practitioner immunisation visits does not decrease.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-168

OUTCOME 1: Population Health and Safety

Topic: ATAGI RECOMMENDATIONS ON VACCINES

Written Question on Notice

Senator McLucas asked:

Does the department have any evidence or advice which supports the resistance to moving to the combination vaccines with injected polio vaccine?

Who has provided this advice, and was this advice received as part of the Minister's request for the review of ATAGI's original recommendation?

Answer:

On 7 March 2005, the government announced funding for the replacement of oral polio vaccine with inactivated polio vaccine, including funding for combination vaccines.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-099

OUTCOME 1: Population Health and Safety

Topic: ADVERSE REACTIONS REPORTING

Hansard Page: CA 99-101

Senator McLucas asked:

a) Can you advise the Committee when was reporting adverse reactions by the TGA website and the 1800 telephone number introduced?

b) In 2002-03 there were approximately 12,000 adverse reaction reports. Is the number static? What has happened over the last couple of years?

c) How many adverse drug reaction reports were received through the:
   (i) traditional reply-paid document?
   (ii) 1800 phone number?
   (iii) TGA website?

d) From where do adverse reaction reports come to the TGA and what is the split between these groups?

Answer:

a) Reporting to the Australian Drug Reaction Advisory Committee website commenced in January 2003. The 1800 telephone number was introduced in June 2002.

b) Total reports received were:

| Year | No. of reports |
|---|---|
| 2002 | 9587 |
| 2003 | 11562 |
| 2004 | 9946 |

c) Statistics for the number of 1800 calls that result in the lodgement of an adverse drug reaction report are not collected currently. The 1800 line received 246 calls in the quarter October 2004 to December 2004. These calls were generally to request information rather than to report an adverse drug reaction. In 2003 there were 484 adverse drug reaction reports submitted using the electronic reporting facility on the TGA website and in 2004 there were 506 reports.

d) Attachment 1 contains a breakdown of the source of adverse drug reaction reports for 2002, 2003 and 2004.

ATTACHMENT 1



TGA

# THERAPEUTIC GOODS ADMINISTRATION

## CAPTURE DURATION - QUARTERLY REPORT

[Report Parameters] [Report Date] [Capture Duration Group] [Case Nos Group] [Request Further Details Flag] [Drug Status] [Submission Type Flag] [Causality Description] [Report Status Description] [Reporter Type Description]

| | 2002 | 2003 | 2004 | |
|---|---|---|---|---|
| Total | 9587 | 11982 | 9948 | |
| Hospital | 2611 | 3033 | 3012 | |
| Drug Company | 2684 | 3313 | 2859 | |
| General Practitioner | 3314 | 2743 | 2082 | |
| Dentist | 5 | 4 | 1 | |
| Specialist | 224 | 253 | 180 | |
| Pharmacist | 461 | 720 | 735 | |
| Member of public | 281 | 368 | 167 | |
| Historical (pre-BME) Record, Reco | 3 | 0 | 0 | |
| Nurse | 3 | 89 | 59 | |
| Complementary Healthcare Profess | 0 | 57 | 10 | |
| State/Territory Health Department | 21 | 382 | 841 | |

Cube Modified Tuesday, 15 February 2005 at 9:47:37 AM

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-100

OUTCOME 1: Population Health and Safety

Topic: ANAO AUDIT REPORT – REGULATION OF NON-PRESCRIPTION MEDICINAL PRODUCTS

Hansard Page: CA 99

Senator McLucas asked:

Is there a document that describes the actions that the TGA is taking in response to the audit? Is there a document the Committee could have a look at that would give us an understanding of the variety of responses that the TGA is undertaking? Could you add to that the timeframe in which you expect these pieces of work to be completed, and also if there are any costs associated with changed practices?

Answer:

The Department has accepted all of the audit report's recommendations. The department is progressing with their implementation. A departmental Audit Sub-committee has been established to oversee, and to report to the Secretary on the implementation of all the recommendations. The sub-committee will also advise the Secretary on any additional improvements that may be warranted in relation to the TGA's administration.

The sub-committee has engaged a consultant to assist its work. The consultant is required to:

- assist the Therapeutic Goods Administration (TGA) in implementing the Australian National Audit Office (ANAO) recommendations, including the development of an implementation strategy;
- undertake a review of recent key enforcement actions by the TGA to draw lessons for the future – this is in line with Recommendation 13 of the audit report; and
- take an overarching view of the TGA's governance frameworks.

The consultant reports to the sub-committee on these tasks, and advises on the sufficiency of the work undertaken by the TGA to meet all the ANAO recommendations. The consultant may also provide the sub-committee with comments and recommendations on broader matters of the TGA's regulatory and governance frameworks. A copy of the Terms of Reference for the consultant is attached.

Deloitte Touche Tohmatsu (Deloitte) has been engaged to undertake the consultancy. The consultant commenced on 19 April 2005 and is expected to complete work by mid to late June 2005.

At the request of the Chair of the Joint Committee of Public Accounts and Audit (JCPAA), at the JCPAA's public hearing on 5 April 2005 into the ANAO report on the TGA, the department has undertaken to report back to the JCPAA on the progress of actions on the ANAO recommendations. The department will also provide this report to the Senate Community Affairs Legislation Committee if required.

The ANAO recommendations will be implemented within the TGA's existing budget.

## Terms of Reference for Consultant

**(Extract from Department of Health and Ageing Request for Proposal and Quotation No. 171/0405)**
**Statement of Requirement**

*Overview*

The Department is seeking proposals/quotations for the provision of a suitably qualified consultant to assist in the development of a strategy to implement the recommendations made by the Australian National Audit Office (ANAO) in their Audit Report No. 18 2004-2005 *Regulation of Non-prescription Medicinal Products*.

*Objectives*

The consultant will be required to:

- Assist the Therapeutic Goods Administration (TGA) in implementing the ANAO recommendations including development of an implementation strategy ;

- Undertake a review of recent key enforcement actions to draw lessons for the future; and

- Review broader aspects of the TGA's administration, management and governance structure and make recommendations where appropriate.

The consultant may also make comment on the regulatory framework and make suggestions for improvement.

*Background*

The Therapeutic Goods Administration (TGA) is part of the Australian Government Department of Health and Ageing, with responsibility for administering the *Therapeutic Goods Act 1989*. The TGA's key objectives in the regulation of therapeutic goods in Australia are to ensure that these goods:

- meet appropriate standards of safety, quality and efficacy; and
- are made available to the community in a timely manner.

The TGA currently regulates over 59,000 therapeutic goods including prescription and non-prescription medicines, medical devices, blood, and blood and tissue products. The number of goods regulated by the TGA is continually increasing as new therapies evolve, new applications for existing therapeutic goods are found, and as international markets continue to expand. Manufacturing techniques are also continually changing and improving with new technology.

The TGA's regulatory framework is enshrined in legislation, regulation and documented procedures. It is based on a risk management approach that devotes more resources and attention to products and manufacturers that are most likely to give rise to harm in the community.

The ANAO conducted a performance audit of the TGA over the period September 2003 until October 2004 and tabled its report in December 2004. The report detailed 26 recommendations which addressed a range of administrative and management issues within the broad categories of risk management, documentation and record keeping and establishment of clear procedures for various administrative actions.

In a number of areas specific recommendations have either been addressed by the TGA or work is underway to address them. However, further work will be required to give effect to other recommendations particularly in the development and implementation of an appropriate risk framework and a performance management system

*Approach to the Consultancy*

The consultant will report to a senior management committee comprising the head of the TGA and two members of the Department's Audit Committee.

The consultant will be expected to work with staff of the TGA in implementing appropriate responses to the ANAO recommendations. This will require reviewing work that is already underway and developing appropriate strategies to address specific recommendations and key themes of the ANAO report. Particular emphasis will be in the following areas:

- reviewing and enhancing the TGA's risk management framework;
- development and implementation of an appropriate performance management system; and
- the planning and implementation of an appropriate organisational, governance and procedural framework.

The consultant will also be required to review a number of enforcement actions taken by the TGA to determine if there are opportunities to further improve aspects of the TGA's procedures and processes.

*Requirements, Skills and Experience of the Contractor*

The successful contractor will need to demonstrate skills and experience commensurate with this important and significant task.

The Department considers that the consultant will be at a senior level and have demonstrated experience in organisational change particularly in the context of a high profile organisation such as the TGA.

*Project Management and Reporting*

The consultant will report to a committee comprising the head of the TGA and senior members of the Department.

*Timetable*

It is expected that the consultant will commence early April 2005, with completion of the assignment by June 2005.

The consultant will be required to develop a realistic timetable after commencement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-072

OUTCOME 1: Population Health and Safety

Topic: FACT SHEET ON CODEX

Hansard Page: CA 103

Senator McLucas asked:

It might be useful if you could direct me to an easy to read, understandable fact sheet on Codex Alimentarius.

Answer:

- *The Codex Alimentarius Commission*, (the commission) was established under the Food and Agriculture Organization (FAO) and the World Health Organization (WHO) of the United Nations in 1963.

- The principal purpose of the commission is the preparation of food safety standards and their subsequent publication in the Codex Alimentarius (or the food code).

- The commission meets every two years. Representation at sessions is on a country basis, with national delegations led by senior officials. Its membership is comprised of countries representing 97 per cent of the world's population.

**THE SCOPE OF THE WORK OF CODEX**

- The Food Standards Program of the commission aims to:
    - protect the health of consumers and ensure fair practices in food trade;
    - promote the coordination of all food standards work undertaken by international governmental and non-governmental organisations;
    - determine the priority of, and initiate and guide the preparation of draft standards through and with the aid of appropriate organisations;
    - finalise standards after acceptance by governments, publishing them in a Codex Alimentarius either as regional or world wide standards, together with international standards already finalised; and
    - amend published standards after appropriate survey in the light of developments.

- An increasing number of countries are aligning their national food standards, or parts of them, with those of the Codex Alimentarius.

## HOW THE WORK OF CODEX IS CONDUCTED

- The finalisation (and revision as necessary) of food standards and their compilation into the Codex Alimentarius involves extensive consultation, collection and evaluation of information.

- The procedures for preparing standards are a defined and open process:
  - submission of a proposal for the development of a standard by a national government or subsidiary committee of the commission;
  - consideration and decision by the commission that the standard be developed as proposed;
  - preparation and circulation of a proposed draft standard by the Commission Secretariat to member governments for comment;
  - consideration of comments and finalisation of a draft standard for presentation to the commission;
  - adoption by the commission of the presented draft standard followed by circulation to governments a number of times; and
  - (upon satisfactory completion) inclusion of the standard in the Codex Alimentarius.

- The commission is aided in its work of preparing food standards by two types of Codex Committees. These are:
  - General Subject Committees (or horizontal committees) in which the work applies to all commodity standards, and
  - Commodity Committees with responsibility for developing standards for specific foods or classes of food (also known as vertical committees).

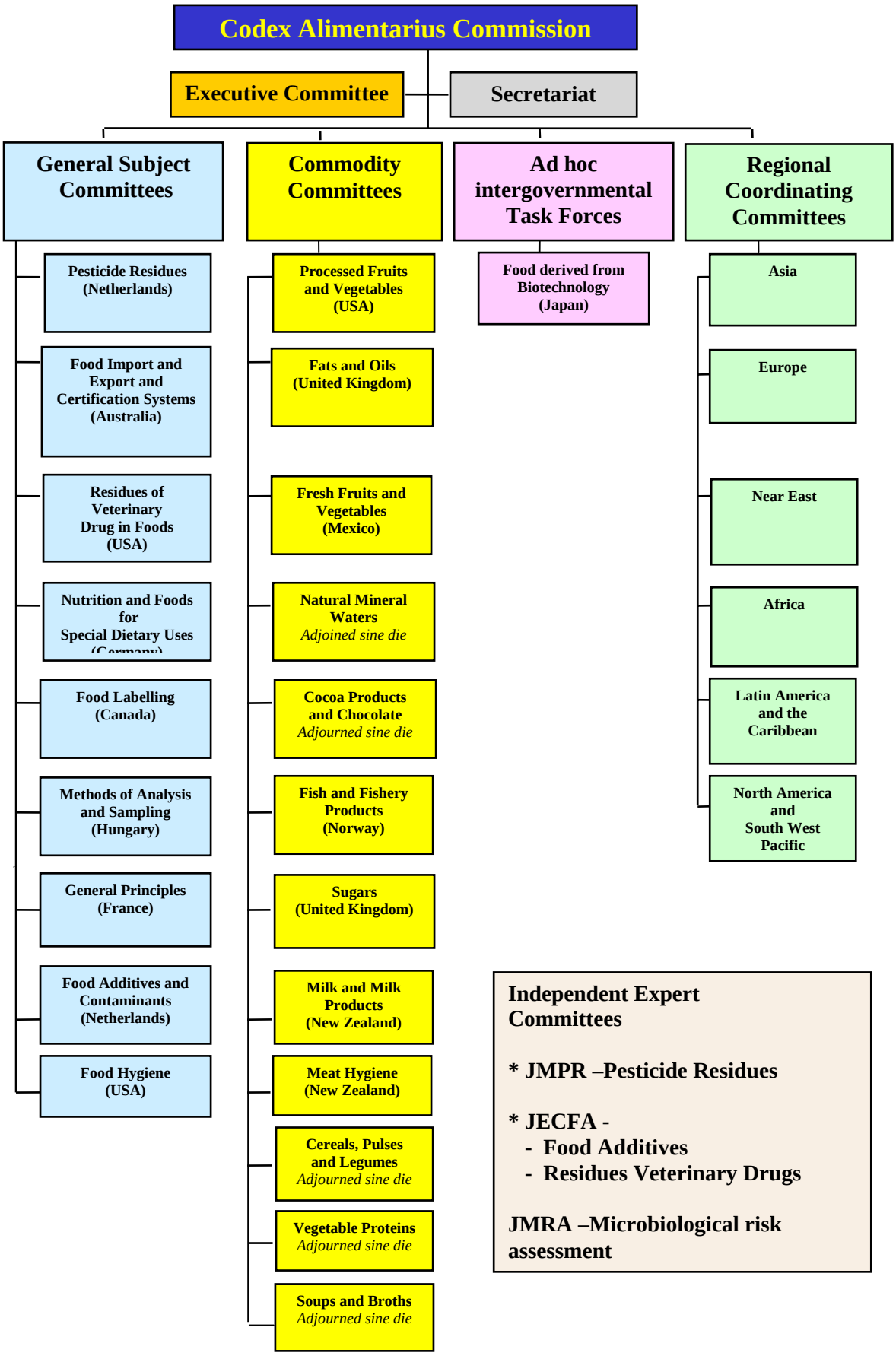
  In addition there are two ad hoc intergovernmental task forces, and six regional coordinating committees.

- There are nine General Subject committees and 12 Commodity Committees. Attachment 1 shows the current committee structure.

- For further information on Codex, visit the website of the Codex Alimentarius Commission at: www.codexalimentarius.net/web/index_en.jsp or in Australia, visit the website of Codex Australia, Department of Agriculture, Fisheries and Forestry at: www.codexaustralia.gov.au or contact Codex Australia by email at: codex.contact@daff.gov.au

**Attachment 1**

## *Joint FAO/WHO Food Standards Program*



Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-157

OUTCOME 1: Population Health and Safety

Topic: TRANS-TASMAN FOOD STANDARD - SUBMISSIONS

Hansard Page: CA 104

Senator McLucas asked:

Can you provide a break-up of the nature of those submissions? How many would be from consumers, how many from industry?

Answer:

- Food Standards Australia New Zealand received a total of 147 submission on its Initial Assessment report on Nutrition, Health and Related Claims.
- 11 submissions were received from government departments.
- 81 submissions were received from industry.
- 15 submissions were received from consumers, including 4 consumer groups (the Australian Consumers' Association; the Consumers' Institute of New Zealand; the National Council of Women; Allergy New Zealand and Anaphylaxis Australia) and 11 individual consumers.
- 33 submissions were received from nutritionists/dietitians, public health and non-government organisations.
- 7 submissions were received from research institutions, partnerships and other various sectors.
- See table below:

| Country | Government | Industry | | Consumers | Public Health* | Other # | **TOTAL** |
|---|---|---|---|---|---|---|---|
| Australia | 9 | Food | 39 | 13 (inc. 11 Consumers, 2 Consumer Groups) | 20 | 4 | **90** |
| | | Therapeutic | 4 | | | | |
| | | Media | 1 | | | | |
| | | **TOTAL** | **44** | | | | |
| New Zealand | 2 | Food | 16 | 1 (Consumer Group) | 13 | 3 | **46** |
| | | Therapeutic | 5 | | | | |
| | | Media | 6 | | | | |
| | | **TOTAL** | **27** | | | | |
| Joint Australia/New Zealand | | Food | 6 | 1 (Consumer Group) | | | **7** |
| | | Therapeutic | | | | | |
| | | Media | | | | | |
| | | **TOTAL** | **6** | | | | |
| International | | Food | 4 | | | | **4** |
| | | Therapeutic | | | | | |
| | | Media | | | | | |
| | | **TOTAL** | **4** | | | | |
| **TOTAL** | **11** | | **81** | **15** | **33** | **7** | **147** |

* includes nutritionists/dietitians, public health and non-government organisations.

# includes research institutions, partnerships and other various sectors.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-047

OUTCOME 1: Population Health and Safety
Topic: APPLICATION FOR LICENCE TO OPERATE THE OPEN POOL AUSTRALIAN LIGHT-WATER (OPAL) REACTOR

Written Question on Notice

Senator Forshaw asked:

In June 2004 Estimates hearings, Dr Loy stated:

They [Australian Nuclear Science and Technology Organisation (ANSTO)] would not, in my view, be able to come forward with an application to operate before our final approvals on all the systems are given.

(a) Have all final approvals on all of the systems been granted by ARPANSA? If so, were these approvals given before ANSTO lodged its application for an operating licence?

(b) In the June 2004 Estimates Dr Loy stated: "I have said many times that I will be looking for progress, such that I can be convinced that there will be a store." Do these requirements still stand?

(c) Further, in discussing the process leading up to a licence to operate being granted, Dr Loy said in June 2003 (referred to in June 2004 Estimates):

"I believe I would need to be satisfied that there were steps being taken that would satisfy me that there will be a store for the spent fuel waste product when it returns from conditioning overseas from the replacement reactor. So it is not that a store will actually be in existence but that there will be sufficient steps taken to satisfy me that one will be in place."

Do you believe that 'sufficient steps' have been taken towards the establishment of a waste store that would enable a licence to operate being granted to ANSTO?

(d) In addition, Dr Loy agreed that evidence would need to be presented that indicates a 'serious proposition' that a store will be up and running. Are you currently aware of a 'serious proposition' for a waste store?

Answer:

(a) Approvals for construction of safety items, under Regulation 54 of the ARPANS Regulations and Licence Condition 4.6, cover detailed design, manufacture and installation. The final approval of design and manufacture had been given for all major safety systems at the time that ANSTO lodged its application for an operating licence. Final approval for installation of several of these systems had not been given prior to ANSTO lodging its application.

(b) The issues relating to arrangements for the disposition and treatment of spent fuel and resulting intermediate level waste remain important considerations in the context of considering a licence to operate the reactor.

(c) and (d)

In July 2004, the Australian Government stated that it now proposed to co-locate the national store for intermediate level waste with the proposed Commonwealth low level waste facility. The government indicated that it will be examining sites on Commonwealth land for these facilities.

The extension for a period of ten years of the Foreign Research Reactor Spent Nuclear Fuel Acceptance Program and its application to the OPAL reactor was announced by the United States Department of Energy in December 2004. ANSTO, in its application for an operating licence, has adopted transfer of US enriched spent fuel to the US as its preferred option for ultimate disposal and transfer of spent fuel for the period of this extension. This period is shorter than the planned life of the OPAL reactor and the issue of the commitment to and timing of establishment of a store will be, in relation to the licensing of the OPAL to operate, a matter upon which the CEO of ARPANSA can expect to receive public submissions. It will also be the subject of advice from the Nuclear Safety Committee.

The CEO of ARPANSA will consider the current disposal and transfer plan, his previously stated opinions, the public submissions and the advice of the Nuclear Safety Committee in coming to his decision on the operating licence.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-048

OUTCOME 1: Population Health and Safety

Topic: APPLICATION FOR LICENCE TO OPERATE THE OPEN POOL AUSTRALIAN LIGHT-WATER (OPAL) REACTOR

Written Question on Notice

Senator Forshaw asked:

(a) At the June 2004 Estimates hearings, attention was drawn to ARPANSA's submission to the Senate Select Committee, where it advised that for a licence to operate:

- the arrangements for reprocessing of its spent fuel would need to be entirely firm;
- with regard to the ILW store, there would need to be substantial and evident progress - such as the features of the design settled, siting criteria established and a strategy and timetable in place for a site(s) - that it was moving forward with clear paths to its future establishment and the CEO could be satisfied that a store will exist.

Does that continue to be your position in regard to the progress that would need to be made at the time you consider the licence to operate?

(b) Are you aware of what progress, if any, has been made towards these steps?

(c) Would you be prepared to grant an operating licence if these requirements have not yet been met?

(d) When was the application for an operating licence lodged?

Answer:

(a) (b) and (c)

The issues relating to arrangements for the disposition and treatment of spent fuel and resulting intermediate level waste remain important considerations in the context of considering a licence to operate the reactor.

In July 2004, the Australian Government stated that it now proposed to co-locate the national store for intermediate level waste with the proposed Commonwealth low level waste facility. The government indicated that it will be examining sites on Commonwealth land for these facilities.

The extension for a period of ten years of the Foreign Research Reactor Spent Nuclear Fuel Acceptance Program and its application to the OPAL reactor was announced by the United States Department of Energy in December 2004. ANSTO, in its application for an operating licence, has adopted transfer of US enriched spent fuel to the US as its preferred option for ultimate disposal and transfer of spent fuel for the period of this extension. This period is shorter than the planned life of the OPAL reactor and the issue of the commitment to and timing of establishment of a store will be, in relation to the licensing of the OPAL to operate, a matter upon which the CEO of ARPANSA can expect to receive public submissions. It will also be the subject of advice from the Nuclear Safety Committee.

The CEO will consider the current disposal and transfer plan, his previously stated opinions, the public submissions and the advice of the Nuclear Safety Committee in coming to his decision on the operating licence.

(d) The application for a licence to authorisation operation of the OPAL research reactor was received on 13 September 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-049

OUTCOME 1: Population Health and Safety

Topic: APPLICATION FOR LICENCE TO OPERATE THE OPEN POOL AUSTRALIAN LIGHT-WATER (OPAL) REACTOR

Written Question on Notice

Senator Forshaw asked:

(a) Can you outline the process and expected timeframe for dealing with the application for an operating licence?

(b) In the past, when considering the approval of various stages of construction of the new reactor, ARPANSA has had the IAEA examine aspects of the applications. Will the IAEA be examining, at any stage, the application for the licence to operate? If so please provide details.

(c) Will ARPANSA be considering international benchmarks and standards when assessing the licence to operate? If so, what are these international standards?

(d) Does ARPANSA plan any form of auditing of the applications for the licence? If so, how will this be undertaken?

Answer:

(a) On receiving the application from the Australian Nuclear Science and Technology Organisation (ANSTO) in September 2004, the CEO of ARPANSA (the CEO) first assessed whether the application met the requirements of the *Australian Radiation Protection and Nuclear Safety Act 1998* (the Act) for a valid application. As Part D of the application, operational limits and conditions, was not provided with the application, the CEO concluded that the application was not complete and advised ANSTO. In October, ANSTO provided this additional information and review of the application by ARPANSA commenced.

An interim public release version of the application was placed upon the ARPANSA website in December 2004. The CEO expects to release a further public version of the application in the near future when matters relating to claims for deletions based upon security and commercial-in-confidence grounds have been resolved.

On 1 December 2004, in accordance with the Act, the CEO advertised that he intended to make a decision and sought public submissions on the interim public version of the application.

The planning timetable for assessment of the application is currently under review. It is anticipated to be close to the following:

- December 2004 – publication of application and call for public submissions;
- International peer review of the application to be completed and published by April 2005;
- Final public version of the application made available in April 2005 with public submissions now called for by July/August 2005;
- Reports by the Nuclear Safety Committee to be received and published by July/August 2005;
- Public forum on the application in October 2005; and
- Second round of public submissions by end November 2005.

During the assessment of the operating licence application, activities will continue under the construction licence. The outcomes of some of these processes will need to be fed back into the operating licence assessment. In particular, the 'cold' commissioning of systems, structures and components important for safety is permitted under the construction licence. These results will be important to check that the performance of systems put forward as part of the safety analysis report is borne out. The final decision on the licence application must await these results.

(b) Yes. An international team of experts under the auspices of the International Atomic Energy Agency (IAEA) arrived on 28 February 2005 and spent two weeks analysing the application. As noted in (a) above, the report of the review team will be made public and will become part of the material that the CEO will take into account when making his decision on the licence application.

(c) Yes. International best practice can be examined at three levels.

The first level is the high level principles about radiation protection and nuclear safety and how they are analysed and reviewed. These are described in a well established safety framework set up through the IAEA and international conventions. The International Nuclear Safety Advisory Group (INSAG), which advises the Director General of the IAEA, set out objectives related to nuclear safety, radiation protection and technical safety. They set out fundamental principles applying to: management responsibility for safety culture, operation, regulatory control and independent verification; defence in depth including accident prevention and mitigation; and general technical principles about proven engineering, quality assurance, human factors etc.

The Convention on Nuclear Safety and the Joint Convention on the Safety of Spent Fuel Management and the Safety of Radioactive Waste Management commit contracting parties (including Australia) to strive to achieve the INSAG objectives and principles in relation to siting, design, construction, operation and regulation of nuclear installations and management of spent fuel and waste management.

The second level relates to the inclusion of a number of reactor safety features in the design of reactors. These include systems to shut down the reactor, to cool the core under various circumstances and to contain and control the release of radioactive material. There is increasing international agreement about the desirable approach to such safety features which is documented in fundamentals, requirements and guidance of the IAEA. It is also a matter that can be addressed by comparing proposed safety features with those built into recently designed and constructed reactors in other countries.

The third level is the detailed codes of practice and safety standards for the design, construction and operation of reactors. At this more detailed level, the choice of generally accepted codes and standards for construction and operation should be consistent and chosen from those used internationally, though there may not be a single set of such codes and standards that alone constitute international best practice.

(d) A peer review of the application is being undertaken under the auspices of the IAEA. Other auditing processes are under consideration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-050

OUTCOME 1: Population Health and Safety

Topic: PROPOSAL FOR THE DISPOSAL OF SPENT FUEL FROM THE OPEN POOL AUSTRALIAN LIGHT-WATER (OPAL) REACTOR IN THE UNITED STATES

Written Question on Notice

Senator Forshaw asked:

(a) It was recently reported in the media in January this year, that ANSTO had reached agreement with the United States to take the spent fuel rods from the new reactor. What is your understanding of this arrangement?

(b) What role, if any, did ARPANSA play in the negotiations of this contract? If ARPANSA was not involved were you consulted about the proposal?

(c) Is the contract subject to approval by ARPANSA? If so, will ANSTO have to make a separate application for approval to ship the fuel rods overseas?

(d) Will any such application need to be finalised before the operating licence is finalised?

(e) Will this contract be made available to the public?

(f) Does an arrangement of this sort for waste disposal change any of your criteria mentioned above with regards to the granting of a licence to operate?

Answer:

(a) In December 2004, the United States Department of Energy announced in a Federal Register Notice a decision to extend the Foreign Research Reactor Spent Nuclear Fuel Acceptance Program for a period of ten years until 2016. The extended program specifically includes the spent fuel arising from the OPAL reactor.

ARPANSA understands that the Australian Nuclear Science and Technology Organisation (ANSTO) has a contract with the United States Department of Energy to accept fuel for the current phase of the Acceptance Program which was due to end in 2006. ARPANSA also understands that ANSTO is proposing to revise this contract with the Department of Energy to cover the extension.

The CEO of ARPANSA (the CEO) will consider these arrangements when he makes his decision on the application for a licence to operate the OPAL reactor.

(b) ARPANSA did not play a role in the negotiation of the extension to the Foreign Research Reactor Spent Nuclear Fuel Acceptance Program or to its application to the OPAL reactor. ARPANSA was informally advised of the negotiations and advised of the outcome in revised plans under the application for an operating licence.

(c) The CEO will consider the proposed arrangements for disposition of the spent fuel in the United States when he makes his decision on the application for a licence to operate the OPAL reactor.

Under the ARPANS Regulations and licence conditions, ANSTO must comply with the Australian Code of Practice for the Safe Transport of Radioactive Materials. The code requires approval of relevant bodies including ARPANSA for the shipment of spent fuel.

(d) No. It is expected that any application to ship spent fuel would be made several years following any decision to grant a licence authorising operation of the reactor.

(e) Release of any contract would be a matter for ANSTO and the United States authorities and subject to satisfying any legal requirements.

(f) The CEO will consider the current disposal and transfer plan, his previously stated opinions, the public submissions and the advice of the Nuclear Safety Committee on these issues in coming to his decision on the operating licence.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-051

OUTCOME 1: Population Health and Safety

Topic: PROPOSAL FOR THE DISPOSAL OF SPENT FUEL FROM THE OPEN POOL AUSTRALIAN LIGHT-WATER (OPAL) REACTOR IN THE UNITED STATES

Written Question on Notice

Senator Forshaw asked:

(a) You [John Loy]are quoted in *The Australian* (21/01/05) as stating that this is an 'important new development which I will take into account in my considerations on this licence'. Is this an accurate report of your comments?

(b) If so, what did you mean and what impact could it have on your earlier statements that you must be satisfied that there is real, tangible progress towards the establishment of a store before you would give approval to operate?

(c) To what extent will ARPANSA need to satisfy itself that the waste will be properly conditioned and stored in the United States? Will you need to travel to the United States to inspect the site and carry out discussions with the Americans?

Answer:

(a) Yes.

(b) The decision by the United States to extend the Foreign Research Reactor Spent Nuclear Fuel Acceptance Program and for ANSTO to adopt transfer of United States enriched spent fuel to the United States as its preferred option for ultimate disposal and transfer of spent fuel for the period of this extension is a change from the approach envisaged at the time of the construction licence application. As the issue is a significant one in the licensing assessment, it is an important development. The matter of the commitment to, and timing of establishment of, a store will be, in relation to the licensing of the OPAL, a matter upon which the CEO of ARPANSA (the CEO) can expect to receive public submissions. It will also be the subject of advice from the Nuclear Safety Committee.

The CEO will consider the current disposal and transfer plan, his previously stated opinions, the public submissions and the advice of the Nuclear Safety Committee in coming to his decision on the operating licence.

(c) The spent fuel would be subject to regulation by a separate jurisdiction. ARPANSA will consult with the United States agencies in relation to the safe storage and disposal of the spent fuel.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-117

OUTCOME 1: Population Health and Safety

Topic: PROPOSAL FOR THE DISPOSAL OF SPENT FUEL FROM THE OPEN POOL AUSTRALIAN LIGHT-WATER (OPAL) REACTOR IN THE UNITED STATES

Hansard Page: CA 104-106

Senator McLucas asked:

In relation to disposition of spent fuel from the proposed Australian Open Pool Light-Water Reactor, is there a contract between the Australian Nuclear Science and Technology Organisation and the United States Department of Energy concerning United States acceptance of the spent fuel from the reactor?

Answer:

In December 2004, the United States Department of Energy announced in a Federal Register Notice a decision to extend the Foreign Research Reactor Spent Nuclear Fuel Acceptance Program for a period of ten years until 2016. The extended program specifically includes the spent fuel arising from the OPAL reactor.

ARPANSA understands that Australian Nuclear Science and Technology Organisation (ANSTO) has a contract with the United States Department of Energy to accept fuel for the current phase of the Acceptance Program which was due to end in 2006. ARPANSA also understands that ANSTO is proposing to revise this contract with the Department of Energy to cover the extension.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-118

OUTCOME 1: Population Health and Safety

Topic: COST OF ASSESSMENT OF LICENCE APPLICATION FOR PROPOSED NATIONAL RADIOACTIVE WASTE REPOSITORY

Hansard Page: CA 106-108

Senator Crossin asked:

In relation to the application by the Department of Education, Science and Training for a licence to prepare a site for the proposed National Radioactive Waste Repository at Site 40a near Woomera in South Australia:

(a) What was the cost of assessing the licence application including a breakdown of costs involved in the public forum held in Adelaide?
(b) What other external reports were commissioned in order to assess the licence application?
(c) How many staff from ARPANSA were involved in the licence assessment process?

Answer:

(a) Expenses incurred by the Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) in assessing the application for a licence to site, construct and operate the proposed National Radioactive Waste Repository totalled $386,353.

Expenses of $94,865 were incurred in conducting the public forum held in Adelaide, comprising:
(i) Staff costs: $38,494
(ii) Consultant costs: $17,580
(iii) Travel costs for participants in the forum including panel members: $15,338
(iv) Venue hire and associated costs: $18,732
(v) Transcription fee: $3,963
(vi) Incidental expenses: $758

(b) A peer review of the licence application was undertaken by a team of international experts under the auspices of the International Atomic Energy Agency and published the following report:

*Radioactive Waste Safety Appraisal – An International Peer Review of the Licence Application for the Australian Near Surface Radioactive Waste Disposal Facility – Report of the IAEA International Review Team* (International Atomic Energy Agency, 2004).

The CEO of ARPANSA also received advice from the Nuclear Safety Committee, established under the *Australian Radiation Protection and Nuclear Safety Act 1998*, on engineered barriers and hydrogeology:

> *Report on the DEST Application for a Licence to Site, Construct and Operate a National Radioactive Waste Repository Addressing Engineered Barriers and Hydrogeological Issues* (ARPANSA Nuclear Safety Committee, April 2004).

The Radiation Health Committee was preparing advice on waste acceptance criteria and transport issues at the time work on the application was suspended.

(c) Approximately 20 ARPANSA staff were involved in the assessment of the application on a part-time basis as part of their overall duties. Two additional staff members were involved in conducting the public consultation process on a part time basis as part of their overall duties.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-119

OUTCOME 1: Population Health and Safety

Topic: FUNDING OF ARPANSA PUBLIC EDUCATION ON ELECTROMAGNETIC ENERGY

Hansard Page: CA 108-110

Senator Humphries asked:

In relation to the public education program ARPANSA runs from the money it receives from the government from the levy on radiocommunications licences each year:

(d) What is the funding provided to ARPANSA each year for public education on electromagnetic energy derived from the levy on radiocommunications licences?

(e) From 1996-97 to date, provide a breakdown of what ARPANSA is doing with that money by way of public education and related activities.

(f) How many public education pamphlets on mobile phones has ARPANSA mailed out each year?

(g) What resources did ARPANSA put into the public information campaign on mobile phones that it undertook with ACA.

Answer:

(a) In 1996-97, the government established the Radiofrequency Electromagnetic Energy (EME) Program. The three elements of the program are:

i. Research into radiofrequency electromagnetic radiation (EMR) issues of relevance to Australia and to complement overseas research activities.
ii. Continuing Australian participation in the World Health Organization's (WHO) international Electromagnetic Field Project to assess the health and environmental effects of EME exposure.
iii. A public information program to disseminate information about RF EME public health issues.

The program is funded through the radiocommunications levy.

In 1998-99, the program funding of $1 million per annum was transferred to the Health Portfolio. It was agreed that $0.7 million per year would be applied to the research program through the National Health and Medical Research Council (NHMRC), with $0.3 million to ARPANSA for the other elements of the program. In 1999, however, funding of $0.25 million was transferred back from ARPANSA to the NHMRC for support of research in that year.

Thus, over the years 1998-1999 to 2004-2005, ARPANSA has received $1.85 million from this program funding. During the period, the contribution to and participation in the WHO program cost approximately $0.5 million.

Prior to 1998-99 the program was administered by the Department of Communications, Information Technology and the Arts (DCITA).

(b) As noted in (a), ARPANSA has received this funding from 1998-99.

In planning and carrying out the public dissemination of information about RF EME public health issues, ARPANSA has had regard to its role and functions as defined by the *Australian Radiation Protection and Nuclear Safety Act 1998*. Its priorities have been to disseminate information based upon objective and thorough assessment of the developing state of scientific knowledge; and on its capacity and knowledge about the measurement of RF radiation.

The activities undertaken by ARPANSA connected with public dissemination of authoritative material are:

- establishing and maintaining a database of all published and current research into possible health effects associated with EME emissions from mobile phones handsets and base stations and related issues. Staff have developed international cooperation with other scientific organisations in order to maintain currency in scientific research programs;
- producing and maintaining a series of 11 fact sheets to help explain current thinking on mobile phone communications and health;
- responding directly to public inquiries on the telephone about mobile phones, particularly base stations, and health;
- providing expert advice to Ministers, government departments and agencies on all aspects of EME exposure;
- participating in information sessions, upon request, when the information to be presented is of significant regional/state/national importance for the requesting organisation, attendees have either a high profile in their organisations or be large in number, the information session contribute to policy setting, and in circumstances where ARPANSA can maintain and can be seen to maintain its independence;
- developing through the Radiation Health Committee and, in 2002, publishing an RF Radiation Protection Standard (Maximum Exposure Levels to Radiofrequency Fields – 3 kHz to 300 GHz). The standard includes a great deal of supporting technical and scientific information and is also supported by additional explanatory material on the ARPANSA website;
- developing a protocol for the reporting of EMR emissions from base stations, the use of which is prescribed in the Australian Communications Industry Forum Code. Staff often provide interpretations and explanations of reports to the general public;

- developing and analysing two surveys of emissions from mobile phone base stations (the second with additional funding of $60,000 supplied by the Mobile Carriers Forum);
- designing, launching and maintaining an EMR health complaints database in order to detect any trends in health complaints;
- supporting the Electromagnetic Energy Reference Group (EMERG). EMERG has community and industry representatives as well as staff from the Department of Health and Ageing, DCITA, Australian Communications Authority (ACA), NHMRC and ARPANSA. EMERG is run by ARPANSA and its twice yearly meetings allow input and discussion from the community and industry on issues relating to EME and health;
- Supporting the EME Program secretariat.

The annual direct cost for these activities (without overheads) is estimated to be around $400,000.

(c) In general the public downloads the information from the ARPANSA website – current rate of downloading is about 800-900 per month.

(d) ARPANSA assisted the ACA to respond to growing concern about the roll-out of 3G technology, including fact sheets, multimedia and provision of more detailed information. The cost associated with this activity was around $20,000.

**Department of Health and Ageing**

Mr Elton Humphrey
Secretary
Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Humphrey

**Request for Amendment to Evidence Provided at Community Affairs Legislation Committee Estimates (Additional Estimates)**
**17 February 2005: Outcome 2, CA40**

I am writing to correct a statement that I made at the Community Affairs Legislation Committee Estimates on 17 February 2005.

Below is the extract from the Hansard that contains the incorrect information about the GP re-entry program.

1. **Senator Moore** – "Have you got any idea how much of the budget has been spent so far in both your programs?"

   **Mr Singh** – "In the case of the general practitioners, none."

   This information was incorrect and in fact should be "at December 2004, we had spent $6,242".

2. **Senator Moore -** "Do these provisions apply to the GPs back to work program that we have just heard about?"

   **Mr Singh –** "In general, yes."

   The response was incorrect and in fact should be "only GPs qualified to practice in Australia, who are currently out of the GP workforce, are eligible to participate in the program."

Thank you for your assistance in making the appropriate changes to the Hansard.

Yours sincerely

Alan Singh
A/g Assistant Secretary
General Practice Programs Branch
24 March 2005

## Consultations

**'Improved PBS Listing and Pricing Arrangements for Generic Medicines**

Generic Medicines Industry Association

Meeting 1: 10 January 2005
Meeting 2: 17 January 2005

Medicines Australia

Meeting 1: 11 January 2005
Meeting 2: 17 January 2005

National Pharmaceutical Services Association

Meeting: 11 January 2005

The Pharmacy Guild of Australia

Meeting: 20 January 2005

Consumer Health Forum

Meeting: 19 January 2005

ATTACHMENT 1

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING
Table 1a: Incidence of Items 16525 (274/5,16545/6)(a), 1994/95 to 2003/04
(Date of Processing - State Service Rendered)

| Year | NSW (c) | VIC | QLD | SA | WA | TAS | NT/ACT (b) | AUST |
|---|---|---|---|---|---|---|---|---|
| 1994/95 | 240 | 312 | 188 | 61 | 191 | 11 | 29 | 1,032 |
| 1995/96 | 237 | 223 | 164 | 49 | 119 | 13 | 21 | 826 |
| 1996/97 | 225 | 172 | 115 | 53 | 62 | 16 | 12 | 655 |
| 1997/98 | 209 | 164 | 116 | 55 | 63 | 10 | 22 | 639 |
| 1998/99 | 187 | 158 | 119 | 54 | 48 | 22 | 9 | 597 |
| 1999/00 | 201 | 208 | 106 | 57 | 46 | 16 | 11 | 645 |
| 2000/01 | 200 | 247 | 125 | 55 | 45 | 10 | 10 | 692 |
| 2001/02 | 198 | 208 | 114 | 57 | 41 | 8 | 10 | 636 |
| 2002/03 | 243 | 171 | 135 | 54 | 31 | 8 | 18 | 660 |
| 2003/04 | 194 | 186 | 140 | 62 | 26 | 11 | 18 | 637 |

(a) Management of second trimester labour.
(b) ACT and NT data are not separately available.
(c) Includes a small number of services rendered overseas in the early years of Medicare.

**COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING**
**Table 1b: Incidence of Item 35643 (6469)(a), 1994/95 to 2003/04**
**(Date of Processing - State Service Rendered)**

| Year | NSW (b) | VIC | QLD | SA | WA | TAS | NT | ACT | AUST |
|---|---|---|---|---|---|---|---|---|---|
| 1994/95 | 34,951 (c) | 20,248 | 11,775 | 972 | 8,331 | 754 | 186 | (d) | 77,217 |
| 1995/96 | 35,221 (c) | 20,118 | 11,756 | 777 | 8,775 | 743 | 161 | (d) | 77,551 |
| 1996/97 | 34,407 (c) | 20,133 | 11,784 | 632 | 8,383 | 699 | 153 | (d) | 76,191 |
| 1997/98 | 33,918 (c) | 19,384 | 11,937 | 601 | 8,278 | 639 | 157 | (d) | 74,914 |
| 1998/99 | 34,287 (c) | 19,379 | 11,908 | 533 | 7,696 | 591 | 99 | (d) | 74,493 |
| 1999/00 | 34,131 (c) | 18,729 | 12,544 | 580 | 7,124 | 481 | 110 | (d) | 73,699 |
| 2000/01 | 35,150 (c) | 18,982 | 13,061 | 546 | 7,552 | 492 | 108 | (d) | 75,911 |
| 2001/02 | 35,368 (c) | 18,360 | 13,124 | 667 | 8,001 | 544 | 144 | (d) | 76,208 |
| 2002/03 | 33,563 (c) | 17,780 | 13,000 | 639 | 7,260 | 910 | 115 | (d) | 73,267 |
| 2003/04 | 32,415 (c) | 17,503 | 13,251 | 674 | 7,539 | 1,038 | 134 | (d) | 72,554 |

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.
(b) Includes a small number of services rendered overseas in the early years of Medicare.
(c) Includes data for ACT. See footnote (d)
(d) Separate data not available. Included in NSW.

PBS Prescriptions by State 2003/04

| | NSW | VIC | QLD | WA | SA | TAS | NT | ACT |
|---|---|---|---|---|---|---|---|---|
| | | | | | | | | |
| Total (million) | 57.5 | 41.6 | 30.5 | 14.5 | 14 | 4.7 | 0.6 | 1.9 |
| | | | | | | | | |
| Per capita | 8.5 | 8.4 | 7.9 | 7.3 | 9.1 | 9.8 | 2.8 | 6 |

5

## Listing and Pricing Arrangements for Generic Medicines

2004 Election Commitment

January 2005

## Background

- The Government is concerned about the long term sustainability of the PBS
- In 2003-04 the PBS cost to taxpayer was $5.6 billion
- PBS growth has been around 12% pa over last 10 years

## What has been done

- The 2002-03 PBS budget measures aimed to:
  - facilitate use of generic medicines
  - improve data analysis
  - realign patient co-payments/safety nets
  - increase information from industry to doctors
  - reduce pharmacy fraud
  - commit to evidence based medicine
  - restrict doctor shopping

1

msac
Medicare Services Advisory Committee
Strengthening evidence-based health care in Australia

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Minister for Health and Family Services
M99007157
- 4 JUN 1999
Signatory: Minister
Response: Approp Action
Chief of Staff
Principal Adviser
Phone Call
Info Note
Campaign
Pers Secretary

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

Dear Minister

I am writing to seek your views about an issue which arose at MSAC's sixth meeting on 19 May.

MSAC has received an application for positron emission tomography (PET), for this diagnostic procedure to be provided at the Wesley Hospital, Brisbane. Currently, this technology is provided at three sites: the Austin and Repatriation Medical Centre, Melbourne, the Royal Prince Alfred Hospital, Sydney, and the Peter MacCallum Cancer Institute. However the first two sites are the only ones which attract rebates.

This application raises several complex issues: there are a vast number of indications for the procedure, yet the United States, for example, has defined only 4-5 validated clinical indicators. The economic issues surrounding PET are also significant, as you would be aware.

After discussion at the meeting, it was agreed that PET's role in the Australian health system needs to be clarified, and appropriate funding models considered, so that the application can be assessed in the broader context. I am aware that you have some views on the issue. Given the implications PET has for the effective use of the health dollar from both a Commonwealth and a State/Territory perspective, I would appreciate your advice on this issue, which centres around appropriate management of the technology.

Clearly this may be an opportunity to demonstrate the effectiveness of MSAC in meeting it current role in evaluating new technologies along evidence-based principles, and in influencing their planned introduction across Australia.

I look forward to hearing your views on this issue in due course.

Yours sincerely

David Weedon

David Weedon
Chair
Medicare Services Advisory Committee

3 June 1999

RECEIVED
4 JUN 1999
Parliamentary Section

7

The Hon Dr Michael Wooldridge
Minister for Health and Aged Care

Professor David Weedon
Chair, Medicare Services Advisory Committee
Sullivan and Nicolaides
73 Nerang Court
SOUTHPORT QLD 4215

Dear Professor ~~Weedon~~ David

Thank you for your letter of 3 June 1999 concerning applications MSAC has received for the provision of positron emission tomography (PET) services.

I agree with your view that there are several issues surrounding this diagnostic procedure which need to be addressed from a national perspective rather than on the basis of a single application, for example issues relating to access to the technology, its appropriate clinical role, and its cost effectiveness.

I think it is appropriate that an assessment of PET along the above lines be undertaken. I have asked my Department to set up a review, with appropriate membership, and I would be grateful if MSAC would contribute to the review by undertaking an assessment of the technology and its cost effectiveness. I will ask my Department to liaise with you on this matter. Suggested terms of reference for the review are attached.

I have written to my State/Territory Ministerial colleagues and informed them of these intentions.

Yours sincerely

Michael Wooldridge

Dr Michael Wooldridge

10 AUG 1999

Suite MG 48 Parliament House Canberra ACT 2600 Telephone (02) 6277 7220 Facsimile (02) 6273 4146

8

## REVIEW OF POSITRON EMISSION TOMOGRAPHY (PET)

### TERMS OF REFERENCE

1. To report on and assess, in conjunction with MSAC, the state of PET technology.

2. To assess, in conjunction with MSAC and with reference to available sources of evidence, the cost effectiveness, effectiveness and safety of PET.

3. To clarify the role(s), if any, of PET in Australian clinical practice, including:
   - determining which indications/applications should be eligible for funding; and
   - where funding is appropriate, determining suitable funding models.

4. To develop a national strategy aimed at ensuring appropriate distribution of and access to PET services.

5. To develop a data management plan to enable the ongoing evaluation of PET.

# Executive summary

## The procedure

Positron emission tomography (PET) is a minimally invasive method of nuclear medicine imaging that uses short-lived radiopharmaceuticals to detect and assess perfusion and metabolic activity in various organ systems. When compared to anatomical information that is provided by radiological techniques such as computed tomography (CT), magnetic resonance imaging (MRI) and radiology, PET can provide information about function and metabolism that is complementary to the structural information provided by these techniques. Most clinical PET imaging uses the radionuclide 2-[$^{18}$F]fluoro-2-deoxy-D-glucose (FDG), a radiolabelled analogue of glucose. It is a relatively new and evolving technology. The methodology for whole body imaging, for example, was only developed in the early 1990s and there have been improvements in both scanner performance and processing techniques since that time.

## Medicare Services Advisory Committee—role and approach

The Medicare Services Advisory Committee (MSAC) is a key element of a measure taken by the Commonwealth Government to strengthen the role of evidence in health financing decisions in Australia. MSAC advises the Minister for Health and Aged Care on the evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures, and under what circumstances public funding should be supported.

A rigorous assessment of the available evidence is thus the basis of decision making when funding is sought under Medicare. The medical literature available on the technology is searched and the evidence is assessed and classified according to the National Health and Medical Research Council (NHMRC) four-point hierarchy of evidence. A supporting committee with expertise in this area then evaluates the evidence and provides advice to MSAC.

## MSAC's assessment of PET

FDG PET is a potentially valuable means of diagnosis for a range of clinical conditions, including oncology, cardiology and neuropsychiatric disorders. The clinical effectiveness of FDG PET has been assessed in this review for six specific clinical questions. These questions were formulated from information on current practice (ie common usage of PET in Australia), the disease area and the purpose of the test (eg evaluation of the extent of the disease before surgery or evaluation of recurrent disease). The areas covered are:

- preoperative staging of non-small cell lung cancer (NSCLC);
- potentially resectable metastatic melanoma;
- residual/recurrent mass in patients treated for malignant glioma;
- suspected recurrence of colorectal cancer (CRC);
- medically refractory epilepsy; and

- assessment of myocardial viability in patients being considered for coronary revascularisation.

There are many other potential uses of PET that have not been addressed in this report due to time constraints. It should not be assumed, therefore, that there is no role for PET in the areas not addressed.

## Safety

It is generally accepted that PET is a noninvasive and relatively safe diagnostic procedure. Safety issues are primarily discussed in terms of the safety of the positron-emitting radiopharmaceutical, rather than the safety of the procedure as a whole.

In a large study of 22 FDG PET centres in the United States no adverse reactions to positron-emitting radiopharmaceuticals were reported for 33,295 retrospective doses of positron-emitting radiopharmaceuticals from before 1994 or 47,876 prospective doses from 1994 to 1997.

The United States Pharmacopoeia (USP) drug information for FDG also indicates that there are no known adverse effects associated with the use of FDG. In addition, radiotracers are generally used in microgram quantities, and the incidence of adverse reactions to very small amounts of labelled molecules is likely to continue to be low.

## Effectiveness

### Diagnostic accuracy

PET has improved diagnostic accuracy over conventional imaging in a number of indications. It has been shown to increase the detection of mediastinal and distant metastases not detected by conventional imaging in the staging of NSCLC. It also has increased sensitivity in detecting metastatic disease in patients with melanoma or CRC who are being considered for surgical resection. However, it still has low sensitivity for detecting early microscopic metastatic disease, which is also the case for other widely available diagnostic technologies. PET can probably also detect viable myocardium that may respond to reperfusion and seems more sensitive and specific than imaging with single photon emission computed tomography (SPECT). The reported sensitivity of PET in medically refractory epilepsy is also relatively high. In each of these examples, PET has demonstrated improvement in diagnostic accuracy, but the degree of improvement is difficult to quantify because of limitations of the study designs, specifically, the way in which cases were selected for studies, the way in which tests were selected for patients, and the way in which appropriate reference standards were selected for comparison.

### Impact on clinical decision making and health outcomes

There are documented examples where the results of PET have led to changes in patient management. An example is the avoidance of surgery in cancer patients with disseminated metastatic disease. If it is assumed that changes in management result in improvements in health outcomes, then it is reasonable to infer that improvements in diagnostic accuracy will lead to improved health outcomes. It is, however, not always clear how changed management will impact on clinical outcomes. It should be noted that

this assumed relationship between diagnostic accuracy and health outcomes is not restricted to PET; the same assumptions will apply to most modern diagnostic technologies, because there is seldom information about their effects on health outcomes.

There is no direct evidence available at this time that can demonstrate that improvements in diagnostic accuracy provided by PET, and any subsequent management changes, lead to improvements in health outcomes for patients. There are two ongoing trials (one in Australia) that will provide valuable information in this regard.

### Cost-effectiveness

At the present time, due to the limited information regarding changes in patient outcomes as a result of PET, the economic evaluations of PET are restricted to the use of models based on assumptions, as there are no trial measures available.

Economic modelling has mainly been used in an attempt to assess the cost-effectiveness of NSCLC and solitary pulmonary nodules. The studies discussed in this report tend to suggest that PET may be cost-effective or even cost-saving, based on the assumptions made. Although these assumptions are plausible, they may not be valid and further validation would be worthwhile. The ongoing randomised trials will provide valuable information to help address these issues.

## Recommendations

MSAC concludes that:

- there is insufficient evidence at this time from which to draw definitive conclusions about the clinical effectiveness and cost-effectiveness of FDG PET;
- in most indications, FDG PET is used in addition to other diagnostic modalities (and this was the case in the diagnostic algorithm used for the current assessment);
- in terms of adverse patient reaction to administration of FDG, FDG PET is safe; and
- further evaluation of the technology is necessary.

## Approved indications

MSAC concludes that, with respect to the indications reviewed, there is insufficient evidence on FDG PET's clinical or cost-effectiveness to warrant unrestricted Medicare Benefits Schedule (MBS) funding.

While unrestricted funding is not warranted at this time, the evidence suggests that FDG PET is safe, potentially clinically effective and potentially cost-effective in the indications

reviewed. On this basis MSAC recommends that FDG PET be funded on an interim basis for the following clinical scenarios.

- Differentiation of benign from malignant lesions in the case of isolated lung nodules. Within this indication MSAC recommends that funding be limited to evaluation of lesions that are considered to be unsuitable for transthoracic fine needle aspiration (FNA) biopsy (due to severe lung disease or location of the lesion) or that have failed pathological characterisation.
- Staging of patients with NSCLC prior to surgery or radiotherapy with curative intent.
- Guiding biopsy to the highest area of activity in primary brain tumour. (While the role of FDG PET in this indication was not specifically evaluated by the NHMRC Clinical Trials Centre, the MSAC supporting committee highlighted the potential value of FDG PET in this area, which is seen to be an important clinical issue warranting interim funding.)
- Evaluation of residual structural abnormalities on diagnostic imaging in patients who are symptomatic following definitive treatment for CRC.
- Differentiation of radiation necrosis from recurrent glioma in patients treated with radiotherapy who have residual structural abnormality on diagnostic imaging.
- Preoperative evaluation of patients being considered for surgical resection of hepatic or lung metastases from CRC.
- Preoperative evaluation of patients being considered for surgical resection of apparently limited metastatic disease from malignant melanoma.
- Evaluation of patients with refractory epilepsy who are being considered for surgery in a comprehensive epilepsy program, where there is inconclusive localising information on standard assessment, including seizure semiology, electroencephalogram (EEG) and MRI.
- Evaluation of patients with ischaemic heart disease and impaired left ventricular function who are being considered for revascularisation where standard viability assessments have been negative.

## Suggested funding mechanism

MSAC recommends that interim funding be made available for the above indications, subject to the provision of data.

MSAC recommends that individual FDG PET facilities' access to interim funding be dependent on those facilities' collection of data relating to FDG PET's clinical and/or cost-effectiveness and the provision of that data to a central coordinating body. Data collection should occur within MSAC-approved prospectively designed studies that are capable of providing evidence to enable more long-term decisions to be made regarding the role of FDG PET in Australian clinical practice.

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Healthcare

# The Australian Government's Review of Positron Emission Tomography: an open door

Philip Davies

MJA 2004; 180 (12): 633

→ Next article in this issue
→ Previous article in this issue
→ Contents list for this issue
→ More articles on Radiology
→ More articles on Oncology
→ More articles on Administration and health services
→ Pdf version of this article
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WARE, FRANCIS AND READ *(page 627)* express some concerns about the processes used in the Australian government's decisions about funding for positron emission tomography (PET). We appreciate the Journal's invitation to comment. I will briefly describe the workings of the Medical Services Advisory Committee (MSAC), the particular processes that have been undertaken in respect of PET, and the recommendations and funding decisions that flowed from those processes.

MSAC advises the Minister for Health and Ageing on the strength of evidence pertaining to new and emerging medical technologies and procedures. In doing so, the committee considers safety, effectiveness and cost-effectiveness, and under what circumstances public funding should be supported.

MSAC consists of eminent surgeons, physicians, health economists and experts in epidemiology and medical research, as well as representatives of consumers and of the Australian Health Ministers' Advisory Council. In addition, for each technology under review, MSAC appoints experts in the relevant fields to supporting committees to help interpret the evidence. Since its inception in 1998, MSAC has established a reputation as one of the foremost sources of advice to government on new healthcare technologies.

The processes surrounding the consideration of PET, including MSAC's assessment, have been as follows:

- In 1999, PET first came to MSAC's attention through applications from the Peter MacCallum Cancer Institute (Melbourne) and the Wesley Hospital (Brisbane).
- In August 1999, the then Minister for Health and Aged Care asked the department to conduct a broader review of PET to determine its proper role in the Australian clinical setting. The review incorporated an assessment by MSAC of PET in six clinical indications, but also considered a range of other matters, including the distribution of services, and workforce and accreditation issues. The review was guided by a steering committee comprising representatives of the medical profession, state and territory governments, and consumers. It received submissions from professional associations, states, hospitals, technology suppliers and medical service providers.[1]
- In May 2000, MSAC concluded that there was insufficient evidence to draw definitive conclusions about PET's clinical effectiveness and cost-effectiveness for the six indications.[2] However, it did recommend that interim funding be made available on condition that facilities collect data to inform longer-term decisions about the role of PET in Australian clinical practice.
- In August 2000, the Minister agreed to implement the recommendations of the broader review, incorporating MSAC's findings. This included a limited expansion of funded PET facilities through a tendering process.
- In May and August 2001, MSAC published further assessments of PET in respect of seven additional indications.[3,4] MSAC again concluded that there was insufficient evidence to warrant unrestricted Medicare funding, but that interim funding should be provided under certain conditions, including that data should be collected to aid further assessment.
- The PET tendering process was completed in September 2001.
- By April 2003, eight facilities were receiving Medicare funding to provide PET services: three in Victoria, two in New South Wales, and one each in South Australia, Western Australia and Queensland.
- Funded facilities are participating in a data collection and evaluation program, as recommended by the PET review. This is expected to be completed in 2006.

MSAC considered PET within the context of a broader review of the

technology, but it applied its normal methods and evaluation criteria. The committee recommended funding for PET both in its initial report in 2000[2] and in subsequent reports in 2001.[3,4] The Minister accepted that advice, and a wide range of PET services now attracts a Medicare benefit. This will continue until MSAC next reviews the technology.

In addition to offering Medicare benefits for PET services, the government is funding the collection of data by service providers to improve the evidence base relating to the use of PET in a wider range of indications. The government does not routinely fund such data collection, but has done so in this case in acknowledgement of the potential impacts of PET on patients and the Australian healthcare system.

Finally, one of the concerns that has been raised about the PET reviews is that the government did not follow the views of individuals who were involved in the processes. But that is by no means unusual. It is common for advisers appointed to MSAC supporting committees to bring a range of views to the table. Indeed, the supporting committees and MSAC itself are constructed to enable a diversity of perspectives to contribute to constructive and rigorous debate and decision making. MSAC's challenge is to marry the published evidence with a diverse range of opinions and come to a definitive conclusion. The examinations of PET have been no exception.

Having provided significant interim funding for PET, and substantial support for further data collection to build the evidence base, the Australian government has accepted MSAC's advice to leave the door open, and will consider further evidence of PET's safety, effectiveness and cost-effectiveness as it emerges in 2006.

1. Report of the Review of Positron Emission Tomography. Canberra: Commonwealth of Australia, 2000. Available at: www.health.gov.au/haf/pet/petfinal.htm (accessed May 2004).
2. Medicare Services Advisory Committee. Positron emission tomography: technology assessment report. Canberra: Commonwealth of Australia, 2000. Available at: www.msac.gov.au/pdfs/msacref02.pdf (accessed May 2004).
3. Medical Services Advisory Committee. Positron emission tomography: assessment report [part 2(i)]. May 2001. Canberra: Commonwealth of Australia, 2002. Available at: www.msac.gov.au/pdfs/msacref10i.pdf (accessed May 2004).
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11


## Pricing arrangements for generic medicines

The government today considered implementation of the election commitment for 12.5% reduction for new brands of already-listed medicines on the PBS and has decided that the reduction would only occur once in any group of price related drugs.

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7 February 2005
ABB009/05

In October 2004, the Commonwealth Government announced that listing of generic versions of existing PBS medicines would be subject to an automatic 12.5 per cent reduction in the government benchmark price with such price reductions also applying to all brands in related therapeutic categories under usual reference pricing arrangements.

The government today considered implementation of the election commitment for 12.5% reduction for new brands of already-listed medicines on the PBS and has decided that the reduction would only occur once in any group of price related drugs.

A price reduction will occur when a new brand of an already listed PBS medicine is added to the PBS. This price reduction will flow to other brands of the same drug and to other drugs in the same price related groups. For example, when the first new generic brand of one of the 'statins' (a therapeutic group of drugs for the treatment of high cholesterol levels) comes forward after the start date, it will need to offer at least a 12.5% price reduction or more, and the new benchmark price will flow to the other statin drugs.

Each price related group of drugs would only be subject to the 12.5% reduction once. The flow-on reductions will apply to both patented and non-patented medicines.

The government has consulted widely on the implementation of this measure, including with Medicines Australia, the Generic Medicines Industry Association, the Pharmacy Guild of Australia and the National Pharmaceutical Services Association (pharmaceutical wholesalers) and Consumers' Health Forum of Australia.

The industry has put out different savings estimates for this measure. It is very difficult to estimate savings accurately as they are sensitive to a number of factors including the number and timing of new brand entries to the PBS. Consultation with industry has provided new information that the government has now taken into account. The savings will be broadly consistent with those announced in the Charter of Budget Honesty ($740 million over the four years to 2007-08).

Currently, the prices paid for generic medicines in Australia are high in comparison with other similar countries. Many new brands of existing PBS listed drugs are added to the list without any price reduction. This measure ensures that taxpayers receive even better value for the medicines subsidised by the PBS.

**Media contact: Kate Miranda, 0417 425 227**

# QUESTIONS AND ANSWERS

## NEW PRICING AND LISTING ARRANGEMENTS FOR GENERIC MEDICINES ON THE PHARMACEUTICAL BENEFITS SCHEME (PBS)

### How will the new policy work?

The 12.5 per cent mandatory price reduction will be applied to the "approved price to pharmacist" (this is the price that the government has negotiated with the manufacturer for a drug) and will:

- Only apply to first new brand of any PBS drug listed, not to a second new brand
- Flow on to all brands of that drug
- Flow on to all forms and strengths of that drug which are administered in the same way
- Flow on to all other drugs in the same category (i.e. therapeutic group)
- Only apply once in each therapeutic group of drugs
- Be applied to combination drugs on a pro-rata basis.

Products which have a price relativity to the new brand drug will be affected by the statutory price reduction, whether or not they are under patent.

### Did the government consult about making this change?

The Australian Government consulted with a range of pharmaceutical industry groups including Medicines Australia (the industry body representing pharmaceutical manufacturers), the Generic Medicines Industry Association, the Pharmacy Guild of Australia, the National Pharmaceutical Services Association (pharmaceutical wholesalers) and consumers.

### When will it start?

Changes are required to the *National Health Act 1953* to implement this policy. It will be introduced into Parliament as soon as possible with an expected implementation date of 1 April 2005.

### I've heard that because of this policy, there may be changes to the price I pay for my medicine. Is this correct?

A product may have a premium if there is another product at the benchmark price that is interchangeable at the patient level (i.e. there must be a product available to the consumer at the lowest possible price).

Such premiums are called "special patient contributions" and are allowed under the *National Health Act 1953* at the discretion of the Minister for Health and Ageing. In practice, companies are able to set this special patient contribution as either a:

- Therapeutic Group Premium (TGP) - one brand across all drugs within a Therapeutic Group must be at the benchmark price, and other brands across all drugs in the group may seek to apply a TGP; or

- Brand Premium (BP) - one brand of each drug must be at the benchmark, and other brands may seek to apply a BP.

Companies may increase the premium that they charge consumers (in addition to patient co-payments) when a new competitor enters. This is no different than at present. The 12.5 per cent does not change the ability for companies to have premiums. Consumers who want to stay with a familiar brand will face the choice of paying the premium. There will always be an interchangeable brand which is at the benchmark price - so that the consumer can choose to pay no more than the co-payment. This has always been an important principle in the Australian reference pricing system.

## We recently increased the co-payment rates for the PBS to $4.60 (for concession card holders) and $28.60 (for general patients). Why do we need to do more about managing the cost of the PBS?

The government is concerned about the long term sustainability of the Pharmaceutical Benefits Scheme. In 2003-04, the PBS cost taxpayers $5.6 billion. With more new and expensive drugs being added all the time, we need to ensure that we can continue to afford the PBS into the future. Some drugs cost thousands of dollars but, if they are subsidised by the PBS, you pay much less.

It is one of the best pharmaceutical subsidy schemes in the world. We therefore need to make sure that we get the best value for money we can for all medicines we list on the PBS, so we can continue to receive its benefits into the future.

## Why do we need to change the way prices for new brands are currently set?

There are over 2600 different branded products listed on the PBS. In general, the prices Australian taxpayers pay for generic medicines are high compared to countries with similar subsidy systems. Some examples are shown in Attachment 1.

Once a patent expires for a medicine, other pharmaceutical manufacturers can produce equivalent products (called generic medicines) and have them listed on the PBS under their own brand name. These manufacturers can offer a reduction to the price of their medicine, thereby setting a new benchmark price and creating price competition. Some choose to do this, but most do not. Therefore price reductions are usually fewer and less than should be expected. The government has identified that savings can be made in this area.

Making these changes will help to encourage people to use generic medicines and reduce the cost of the PBS, thereby helping to sustain it into the future.

## Will this measure discourage new drugs from being listed on the PBS?

The PBS is an uncapped program within the Commonwealth Budget. Savings from this measure are returned to the government and provide capacity for reallocation to critical health priorities. Any savings in the PBS reduce spending in the Health and Ageing portfolio, which is expected to make it easier for the government to have new medicines listed.

## Does the measure ensure that patented medicines are fairly priced?

The existence or otherwise of a patent is not an indicator of the value of the health outcome a medicine can provide. Higher prices are paid for innovative medicines with better health outcomes regardless of their patent status.

The purpose of a patent is to prevent unfair commercial exploitation of the intellectual property, which is the subject of that patent. Patents have no role in pricing a product or protecting price. The price paid for medicines listed on the PBS is determined by the health outcomes they provide, regardless of their patent status.

This policy may reduce the price paid for originator brands, but in many cases manufacturers will be able to add a brand premium or a therapeutic group premium that a consumer will need to pay in addition to the co-payment. (There will always be one brand available to the consumer that can be brought for just the co-payment amount.) New drugs will not be affected by this policy unless they have a pricing relativity to an existing drug which is affected by a price reduction.

## How does this policy work within the agreements made under the Australia United States Free Trade Agreement (AUSFTA)?

No agreements made under the AUSFTA are affected by this measure. Pricing for medicines in Australia is a domestic policy concern and has not been affected by the agreement.

**Attachment 1**

**Drug Price Comparisons – Australia – United Kingdom – New Zealand** (compiled 24 November 2004)

| All prices in AUD pro rata to 30 tabs/caps | | UK[1] | NZ[2] | AUST | No of PBS brands | % price decrease since new brands* | Date first new brand | PBS govt cost by drug 2003-04# |
|---|---|---|---|---|---|---|---|---|
| Aciclovir 200mg | viral infections | $11.83 | $2.75 | **$62.45** | 4 | 8% | Feb 1995 | $8.5 M |
| Ciprofloxacin 750mg | antibiotic | $128.68 | $29.33 | **$199.29** | 6 | 6% | Aug 1995 | $11.3 M |
| Norfloxacin 400mg | antibiotic | $26.07 | $25.29 | **$41.98** | 9 | 10.4% | May 2002 | $2.3 M |
| Citalopram 20mg | depression | no generic | $3.93 | **$33.43** | 6 | 11% | Aug 2001 | $44.7 M |
| Fluoxetine 20mg | depression | $4.97 | $1.45 | **$33.03** | 9 | 42.5%** | Feb 1996 | $27.6 M |

* cumulative reductions in PBS price since listing of first additional brand.

** price reductions include the impact of changes other than entry of new brands such as the effect of changes in the level of restriction – for example the removal of the Authority requirements for the Selective Serotonin Re-uptake Inhibitors (eg fluoxetine) and Proton Pump Inhibitors (eg omeprazole).
# includes all forms and strengths of that drug.

1 http://www.dh.gov.uk/PolicyAndGuidance/MedicinesPharmacyAndIndustry/GenericMedicines/MaximumPriceScheme/ListOfMaximumPriceGenericMedicines/fs/en?CONTENT_ID=4026674&chk=Vw8wqY

2 http://www.pharmac.govt.nz/interactive/index.asp

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-041

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

On a number of previous occasions both during Senate Estimates and in written answers given to me, I recall being advised by the Department that prior to any additional PET scanners being licensed, an evaluation due to finish in 2005 would take place.

I have a particular interest in this because there is no publicly funded PET scanner in Tasmania.

However I note that a new scanner is to be funded through these Additional Estimates at Westmead Hospital in Western Sydney, making three in NSW and still none in Tasmania.

(a) Did the evaluation finish earlier than expected?

(b) If so when? Have its findings been published?

(c) If not when is the evaluation expected to be completed and when will its findings be published?

Answer:

(a) No.

(b) Not applicable.

(c) The evaluation is expected to be completed by mid 2006. The results will be published as soon as practicable after the completion date.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-042

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

I note in a media release from Minister Abbott on 19 September last year in relation to this newly licensed machine, the following comments,

'PET is an emerging technology that uses radiation to take finely detailed images of hard and soft tissue from all angles. Its images are particularly valuable in detecting and diagnosing cancers, particularly tumours that evade other forms of diagnostic imaging.

Better diagnostic imaging minimises the need for more invasive tests and procedures that create so much stress for patients and families.'

(a) Does this indicate a change of attitude towards PET scanning, given the past advice that "the jury was still out" on its value?

(b) Did this change of attitude occur before the evaluation being completed?

(c) In these circumstances, why has local access to publicly funded PET scanning not been provided to the people of Tasmania?

(d) Was there anything in particular that caused the change of heart and attitude towards PET scanning that seems to be evidenced by the statement by the Minister and the decision to fund the additional scanner in NSW?

Answer:

(a) & (b)
There has been no change in attitude towards PET scanning. The Minister's statement is consistent with government PET policy, which is informed by the Medical Services Advisory Committee's view that PET is an emerging technology.

(c) The government's evaluation of PET is continuing, and any decisions in relation to the expansion of PET services will take account of the evaluation's results.

(d) The decision to fund an additional PET facility in NSW was an election commitment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-043

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

I note also in the Minister's media release that as at 19 September 2005 there were eight other Medicare funded PET scanners, whereas all the previous information provided to us indicated that there were seven. The extra one appears to be in Victoria.

(a) Where is this located? When and why was the decision made to fund it?
(b) Why was this decision taken prior to the end of the evaluation?

Answer:

(a) Seven Medicare-funded PET facilities were identified through a tender process in 2001. These are:

| | |
|---|---|
| New South Wales | Royal Prince Alfred Hospital |
| | Liverpool Hospital |
| Victoria | Peter MacCallum Cancer Institute |
| | Medical Imaging Australasia (Monash Medical Centre) |
| Queensland | Wesley Hospital |
| Western Australia | Sir Charles Gairdner Hospital |
| South Australia | Royal Adelaide Hospital |

An eighth facility is funded through a grant and is located at Austin Health (formerly the Austin and Repatriation Medical Centre) in Melbourne. This facility was funded under arrangements in place prior to the PET tender. In September 2003, the government entered into a grant funding arrangement with Austin Health, replacing the earlier funding arrangements.

(b) The Austin Health PET facility was funded to provide PET services prior to the commencement of the evaluation and is a participant in that evaluation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-044

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Written Question on Notice

Senator Denman asked:

(a) Other than those who received assistance through the Isolated Patients Travel and Accommodation Assistance Scheme (IPTAA), how many Tasmanians travelled to (i) Victoria and (ii) other states and territories for a PET scan in (I) 2003 – 2004 and (II) to date in 2004-2005?

(b) How many Tasmanians in 2003-2004 travelled to (i) Victoria and (ii) other states and territories for a PET scan under the IPTAA scheme?

(c) How many Tasmanians to date in 2004-2005 have travelled to (i) Victoria and (ii) other states and territories for a PET scan under the IPTAA scheme?

Answer:

(a) There are no data available on the number of Tasmanian patients who travel interstate for a PET scan by their own means.

(b) The department sources IPTAA data from the Tasmanian Department of Health and Human Services. The data specified in these questions has been requested and will be forwarded when available.

The department therefore currently has data only by calendar year for 2003 and 2004.

In 2003, 241 Tasmanians travelled to Victoria for a PET scan under the IPTAA scheme. It is a criterion of the IPTAA scheme that the Tasmanian resident be referred to the nearest appropriate specialist. There are therefore no patients receiving assistance under this scheme who travel to states other than Victoria.

In 2004, there were 303 patients who travelled to Victoria for a PET scan with IPTAA assistance.

(c) The department has no IPTAA data for 2005. This data has been requested and will be forwarded when available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-095

OUTCOME 2: Access to Medicare

Topic: POSITRON EMISSION TOMOGRAPHY (PET)

Hansard Page: CA 45

Senator Harradine asked:

Did the then Minister indicate that a PET scanner would be provided for Tasmania?

Answer:

The department has no record of Minister Wooldridge indicating that a PET scanner would be provided for Tasmania and is not otherwise aware of any such offer.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-045

OUTCOME 2: Access to Medicare

Topic: COMMUNITY PHARMACY AGREEMENT

Written Question on Notice

Senator Denman asked:

I read in the November 2004 issue of the *Australian Journal of Pharmacy* that there have been considerable delays in the implementation of several programs funded through the third Community Pharmacy Agreement. As a result there is a likelihood of a substantial underspend of more than $60 million by the end of the agreement in June 2005:

(a) Which programs have been affected by these delays?

(b) Can you tell me what the amount of the underspend is likely to be at the end of the agreement?

(c) What is the department doing to ensure all allocated funds are spent before 30 June 2005?

(d) If all the allocated funds are not spent by then, how will this underspend be taken into account in the next agreement?

(e) What processes will be put in place in the next agreement to ensure that this sort of underspend does not occur again?

Answer:

(a) Most programs have been affected by delays. The third Community Pharmacy Agreement (CPA) provides funding of $397 million over five years from 1 July 2000, for a range of programs. Whilst some initiatives were identified in the CPA, which was signed on 16 May 2000, virtually all programs had to be developed and implemented after the CPA commenced. This meant that none of the new programs were able to commence on 1 July 2000.

(b) The current estimated underspend will be in excess of $65 million.

(c) The development and implementation of programs is still continuing.

(d) The third CPA includes a provision that unspent funds will be taken into account in the next agreement. The underspend will be considered by the government in the context of the negotiations for the fourth CPA.

(e) This is a matter for the government in considering its arrangements for the fourth CPA.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-175

OUTCOME 2: Access to Medicare

Topic: COMMUNITY PHARMACY AGREEMENT

Written Question on Notice

Senator McLucas asked:

A recent study published in the British Medical Journal showed that home medication reviews were associated with a higher rate of hospital admissions, and did not significantly improve quality of life or reduce deaths.

(a) Is there any evidence that this is also the case in Australia?

(b) Has the department examined this issue in the Australian context?

(c) Are there plans to look at this, given that the funding for Home Medication Reviews will be incorporated into the new Pharmacy Agreement currently under negotiation?

Answer:

(a) The department is not aware of any evidence to suggest that this is the case in Australia as the nature of the United Kingdom Medication Review model is different to that of the Australian Home Medicines Reviews adopted in Australia.

(b) The United Kingdom model is significantly different to the Australian model. In the United Kingdom study, patients received a review only on discharge from hospital, with follow-up being provided by the hospital pharmacist. In the Australian Home Medicines Review model, the patient's usual community pharmacy provides the service in collaboration with the patient's general practitioner, thereby offering greater continuity of care and better access to full medical and medication history. The United Kingdom study does not refer to any collaboration with the patient's general practitioner. The patients in the United Kingdom study were all over 80 years of age who had been admitted to hospital. The Australian model has no age limit and is available to patients in the community as well as on discharge from hospitals.

(c) The Australian Home Medicines Reviews program is part of the third Community Pharmacy Agreement. The program is being evaluated and a final report is due in June 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-176

OUTCOME 2: Access to Medicare

Topic: PBS - PHARMACY REVIEWS

Written Question on Notice

Senator McLucas asked:

(a) What is the current status of negotiations with regard to the Pharmacy review?

(b) Which stakeholders are involved in the negotiations and are these negotiations being conducted from the Department of Health or the Minister's office?

Answer:

(a) The government is considering its position on future funding for pharmacists under a Fourth Community Pharmacy Agreement.

(b) The Department of Health and Ageing will commence discussions with the Pharmacy Guild of Australia when the government’s position is finalised.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-059

OUTCOME 2: Access to Medicare

Topic: ABORTION STATISTICS

Written Question on Notice

Senator Harradine asked:

(i) What is the Department doing to ensure the collection of accurate and comprehensive statistics on abortion in Australia?

(ii) Isn't the Australian public entitled to accurate statistics on such a common operation, as they do on various other health-related issues?

Answer:

(i) There is no single authoritative or complete data source on termination of pregnancies in Australia. It is possible to combine data from a number of sources to provide an estimate of the number of terminations each year. The department can obtain statistics from the National Morbidity Casemix Data Set (NMDS) and the Medicare data. The NMDS includes information against a number of codes which together indicate the number of terminations occurring in public and private hospitals. This information is provided by the states and territories under the Australian Health Care Agreements. The Medicare data collected through the Health Insurance Commission provides information on the number of items claimed out of hospital, including those for termination of pregnancy.

The quality of the source data reported through the NMDS is a matter for states and territories.

(ii) The department is unable to comment on questions seeking opinions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-067

OUTCOME 2: Access to Medicare

Topic: ABORTION STATISTICS

Written Question on Notice

Senator Harradine asked:

In answer to question E04-040 (b) the department acknowledges "There is no single authoritative or complete data source on induced abortions in Australia". Its best estimate is "within the range of 73,000-95,000 each year."

(a) Does the department agree that it is unacceptable to have figures on abortion which are so unclear it cannot be known whether there are 20,000 more or less?

(b) Are there other medical procedures for which it is not known how many are performed a year? If so, what are they?

Answer:

(a) There is no single authoritative or complete data source on terminations of pregnancies in Australia. This means that it is not possible to give a precise number of terminations each year. At the time question E0-040 was answered, the estimate of 73,000 – 95,000 abortions was the best available. However, since then, the department has undertaken further analysis on its data sources and now believes that there are approximately 90,000 abortions carried out each year in Australia. This is based on statistics available through the National Morbidity Casemix Data Set and Medicare data.

(b) Yes. There are many items in the MBS that cover more than one medical indication for a procedure. The data for these items cannot be disaggregated to provide statistics on the indications as this is a confidential matter between the doctor and the patient. Two examples of this are:

Item 38456 - intrathoracic operation on heart, lungs, great vessels, bronchial tree, oesophagus or mediastinum, or on more than one of those organs, not being a service to which another item in this group applies.

Item 43512 - operation on scapula, sternum, clavicle, rib, ulna, radius, metacarpus, phalanx, tibia, fibula, metatarsus, tarsus, mandible or maxilla, one bone or any combination of adjoining bones.

There are numerous medical indications for the procedures done under these items, and it is not possible to determine the number of services that relate to the individual components of the items.

The department could provide a complete list of such items. However, because of the extensive work involved in individually assessing over 4,000 items to determine the extent to which more than one indication is covered by the procedure or procedures, the department has not undertaken this work.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-068

OUTCOME 2: Access to Medicare

Topic: ABORTION STATISTICS

Written Question on Notice

Senator Harradine asked:

In answer to question E04-040 (c) the department says it "has not done any work to determine how to collect national statistics on abortion. This type of work would normally be done by a body like the Australian Institute for Health and Welfare."

(a) Why has this work not been done previously by the Australian Institute for Health and Welfare (AIHW)?

(b) Could the department recommend AIHW undertake this work?

Answer:

(c) The AIHW depends on data from sources outside the AIHW. Its work is therefore limited by the lack of a single authoritative data source on termination of pregnancy.

(d) The AIHW determines its own work program, so it would be an AIHW decision on whether or not the work would be undertaken.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-069

OUTCOME 2: Access to Medicare

Topic: ABORTION STATISTICS

Written Question on Notice

Senator Harradine asked:

In answer to question E04-054 at the February additional estimates hearings in 2003-2004 the Department provided statistics on abortions funded by Medicare. I notice that the Minister for Human Services, the Hon Joe Hockey MP, recently quoted figures by age group of the women concerned. Please provide an updated table to match the one provided earlier (question E04-054, Additional Estimates, 18 February 2004), including the number of services and benefits paid for 1999-2000, 2000-01, 2001-02, 2002-03 and 2003-04, with the additional criteria of being by age group of the women accessing the service.

Answer:

The definitions of medical services included in the Schedule to the *Health Insurance Act* which may result in the termination of pregnancy appear in the Medicare Benefits Schedule as follows:

***ITEM 16525*** - *MANAGEMENT OF SECOND TRIMESTER LABOUR, WITH OR WITHOUT INDUCTION, FOR INTRAUTERINE FOETAL DEATH, GROSS FOETAL ABNORMALITY OR LIFE THREATENING MATERNAL DISEASE, NOT BEING A SERVICE TO WHICH ITEM 35643 APPLIES* (effective from 1 November 1995). Prior to 1 November 1995, the relevant item was ***Item 274/5, 16545/6*** - *MANAGEMENT OF SECOND TRIMESTER LABOUR, WITH OR WITHOUT INDUCTION*.

***ITEM 35643 (6469)*** - *EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE NOT BEING A SERVICE TO WHICH ITEM 35639/35640 APPLIES, INCLUDING PROCEDURES TO WHICH ITEM 35626, 35627 OR 35630 APPLIES, WHERE PERFORMED.*

The requested statistics for Item 16525 are presented as Tables 1A (services) and 1B (benefits), while the requested statistics for Item 35643 are presented as Tables 2A (services) and 2B (benefits).

These statistics only relate to services rendered on a ‘fee-for-service’ basis for which Medicare benefits were paid in each of the years in question. Excluded are details of services to public patients in hospital and through other publicly funded programs.

**TABLE 1A: MEDICARE - ITEM 16525**
**NO. OF SERVICES BY AGE RANGE AND STATE/TERRITORY OF SERVICE PROVISION**
**1999-00 TO 2003-04**

| Year | Age Range | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **1999-00** | **< 20** | 10 | 28 | n.a. | 0 | n.a. | n.a. | n.a. | n.a. | 42 |
| | **20- 24** | 11 | 32 | n.a. | n.a. | n.a. | 0 | n.a. | n.a. | 50 |
| | **25- 34** | 108 | 101 | 60 | 41 | 23 | 6 | n.a. | n.a. | 345 |
| | **35+** | 72 | 47 | 43 | n.a. | 20 | n.a. | n.a. | n.a. | 208 |
| | **Total** | **201** | **208** | **106** | **57** | **46** | **16** | **n.a.** | **n.a.** | **645** |
| **2000-01** | **< 20** | n.a. | n.a. | 0 | 0 | n.a. | 0 | n.a. | n.a. | 31 |
| | **20- 24** | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 63 |
| | **25- 34** | 106 | 107 | 60 | 31 | 29 | n.a. | n.a. | n.a. | 343 |
| | **35+** | 81 | 71 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 255 |
| | **Total** | **200** | **247** | **125** | **55** | **45** | **10** | **n.a.** | **n.a.** | **692** |
| **2001-02** | **< 20** | n.a. | n.a. | n.a. | 0 | 0 | n.a. | n.a. | n.a. | 24 |
| | **20- 24** | n.a. | n.a. | 0 | n.a. | n.a. | n.a. | n.a. | n.a. | 40 |
| | **25- 34** | 114 | 102 | 66 | 36 | 24 | n.a. | n.a. | n.a. | 352 |
| | **35+** | 66 | 67 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 220 |
| | **Total** | **198** | **208** | **114** | **57** | **41** | **8** | **n.a.** | **n.a.** | **636** |
| **2002-03** | **< 20** | n.a. | 0 | n.a. | 0 | 0 | 0 | n.a. | n.a. | 8 |
| | **20- 24** | n.a. | n.a. | n.a. | 0 | 0 | n.a. | n.a. | n.a. | 21 |
| | **25- 34** | 132 | 98 | 71 | 29 | 19 | n.a. | n.a. | n.a. | 360 |
| | **35+** | 95 | n.a. | 56 | 25 | 12 | n.a. | n.a. | n.a. | 271 |
| | **Total** | **243** | **171** | **135** | **54** | **31** | **8** | **n.a.** | **n.a.** | **660** |
| **2003-04** | **< 20** | n.a. | n.a. | 0 | 0 | 0 | n.a. | n.a. | n.a. | 13 |
| | **20- 24** | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 33 |
| | **25- 34** | 112 | 104 | 88 | 38 | n.a. | n.a. | n.a. | n.a. | 378 |
| | **35+** | 76 | 52 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 213 |
| | **Total** | **194** | **186** | **140** | **62** | **26** | **11** | **n.a.** | **n.a.** | **637** |

n.a. not available for confidentiality reasons - included in totals**.**

**TABLE 1B: MEDICARE - ITEM 16525**
**BENEFITS PAID BY AGE RANGE AND STATE/TERRITORY OF SERVICE PROVISION**
**1999-00 TO 2003-04**

| Year | Age Range | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **1999-00** | **< 20** | 1,590 | 4,754 | n.a. | 0 | n.a. | n.a. | n.a. | n.a. | 7,017 |
| | **20- 24** | 1,869 | 5,427 | n.a. | n.a. | n.a. | 0 | n.a. | n.a. | 8,475 |
| | **25- 34** | 18,347 | 17,230 | 10,204 | 6,952 | 3,884 | 1,021 | n.a. | n.a. | 58,654 |
| | **35+** | 12,221 | 7,954 | 7,321 | n.a. | 3,377 | n.a. | n.a. | n.a. | 35,271 |
| | **Total** | 34,027 | 35,365 | 18,029 | 9,654 | 7,765 | 2,712 | n.a. | n.a. | 109,416 |
| **2000-01** | **< 20** | n.a. | n.a. | 0 | 0 | n.a. | 0 | n.a. | n.a. | 5,356 |
| | **20- 24** | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 10,715 |
| | **25- 34** | 18,219 | 18,297 | 10,311 | 5,347 | 4,997 | n.a. | n.a. | n.a. | 58,885 |
| | **35+** | 13,917 | 12,072 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 43,711 |
| | **Total** | 34,368 | 42,079 | 21,551 | 9,503 | 7,737 | 1,716 | n.a. | n.a. | 118,667 |
| **2001-02** | **< 20** | n.a. | n.a. | n.a. | 0 | 0 | n.a. | n.a. | n.a. | 4,172 |
| | **20- 24** | n.a. | n.a. | 0 | n.a. | n.a. | n.a. | n.a. | n.a. | 6,948 |
| | **25- 34** | 19,761 | 17,668 | 11,533 | 6,136 | 4,177 | n.a. | n.a. | n.a. | 61,022 |
| | **35+** | 11,476 | 11,698 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 38,210 |
| | **Total** | 34,399 | 36,108 | 19,854 | 9,795 | 7,077 | 1,392 | n.a. | n.a. | 110,352 |
| **2002-03** | **< 20** | n.a. | 0 | n.a. | 0 | 0 | 0 | n.a. | n.a. | 1,408 |
| | **20- 24** | n.a. | n.a. | n.a. | 0 | 0 | n.a. | n.a. | n.a. | 3,761 |
| | **25- 34** | 23,413 | 17,382 | 12,656 | 5,158 | 3,413 | n.a. | n.a. | n.a. | 63,978 |
| | **35+** | 16,863 | n.a. | 9,960 | 4,421 | 2,141 | n.a. | n.a. | n.a. | 48,087 |
| | **Total** | 43,110 | 30,290 | 24,065 | 9,580 | 5,553 | 1,430 | n.a. | n.a. | 117,234 |
| **2003-04** | **< 20** | n.a. | n.a. | 0 | 0 | 0 | n.a. | n.a. | n.a. | 2,432 |
| | **20- 24** | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 6,038 |
| | **25- 34** | 20,442 | 18,943 | 16,007 | 6,906 | n.a. | n.a. | n.a. | n.a. | 68,885 |
| | **35+** | 13,692 | 9,465 | n.a. | n.a. | n.a. | n.a. | n.a. | n.a. | 38,675 |
| | **Total** | 35,265 | 33,936 | 25,509 | 11,281 | 4,753 | 2,001 | n.a. | n.a. | 116,031 |

n.a. not available for confidentiality reasons - included in totals.

**TABLE 2A: MEDICARE - ITEM 35643**
**NUMBER OF SERVICES BY AGE RANGE AND STATE/TERRITORY OF SERVICE PROVISION**
**1999-00 TO 2003-04**

| Year | Age Range | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **1999-00** | **< 20** | 4912 | 2268 | 2079 | 39 | 1230 | 78 | n.a. | (a) | 10607 |
| | **20- 24** | 8396 | 4306 | 3261 | 55 | 1950 | 106 | n.a. | (a) | 18090 |
| | **25- 34** | 14196 | 8187 | 5014 | 267 | 2794 | 201 | 61 | (a) | 30720 |
| | **35+** | 6627 | 3968 | 2190 | 219 | 1150 | 96 | 32 | (a) | 14282 |
| | **Total** | **34131** | **18729** | **12544** | **580** | **7124** | **481** | **110** | **(a)** | **73699** |
| **2000-01** | **< 20** | 5113 | 2295 | 2118 | 36 | 1291 | 101 | 12 | (a) | 10966 |
| | **20- 24** | 8439 | 4362 | 3264 | 42 | 1926 | 98 | 14 | (a) | 18145 |
| | **25- 34** | 14685 | 8193 | 5348 | 260 | 3026 | 192 | 54 | (a) | 31758 |
| | **35+** | 6913 | 4132 | 2351 | 208 | 1309 | 101 | 28 | (a) | 15042 |
| | **Total** | **35150** | **18982** | **13081** | **546** | **7552** | **492** | **108** | **(a)** | **75911** |
| **2001-02** | **< 20** | 4882 | 2180 | 2099 | 27 | 1426 | 100 | 16 | (a) | 10730 |
| | **20- 24** | 8416 | 4240 | 3127 | 58 | 1968 | 139 | 8 | (a) | 17956 |
| | **25- 34** | 14815 | 7952 | 5512 | 327 | 3140 | 211 | 87 | (a) | 32044 |
| | **35+** | 7255 | 3988 | 2386 | 255 | 1467 | 94 | 33 | (a) | 15478 |
| | **Total** | **35368** | **18360** | **13124** | **667** | **8001** | **544** | **144** | **(a)** | **76208** |
| **2002-03** | **< 20** | 4801 | 2047 | 2101 | 25 | 1301 | 186 | 17 | (a) | 10478 |
| | **20- 24** | 7845 | 3999 | 3209 | 49 | 1787 | 233 | 10 | (a) | 17132 |
| | **25- 34** | 13907 | 7559 | 5298 | 300 | 2881 | 332 | 56 | (a) | 30333 |
| | **35+** | 7010 | 4175 | 2392 | 265 | 1291 | 159 | 32 | (a) | 15324 |
| | **Total** | **33563** | **17780** | **13000** | **639** | **7260** | **910** | **115** | **(a)** | **73267** |
| **2003-04** | **< 20** | 4662 | 2044 | 2090 | 22 | 1395 | 212 | 13 | (a) | 10438 |
| | **20- 24** | 7457 | 3907 | 3208 | 42 | 1860 | 240 | 18 | (a) | 16732 |
| | **25- 34** | 13189 | 7338 | 5422 | 342 | 2862 | 393 | 56 | (a) | 29602 |
| | **35+** | 7107 | 4214 | 2531 | 268 | 1422 | 193 | 47 | (a) | 15782 |
| | **Total** | **32415** | **17503** | **13251** | **674** | **7539** | **1038** | **134** | **(a)** | **72554** |

(a) not available for confidentiality reasons - included in NSW.
n.a. not available for confidentiality reasons - included in totals.

**TABLE 2B: MEDICARE - ITEM 35643**
**BENEFITS PAID BY AGE RANGE AND STATE/TERRITORY OF SERVICE PROVISION**
**1999-00 TO 2003-04**

| Year | Age Range | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| **1999-00** | **< 20** | 673,529 | 304,902 | 294,241 | 4,887 | 173,806 | 10,731 | n.a. | (a) | 1,462,221 |
| | **20- 24** | 1,150,608 | 575,991 | 460,114 | 6,899 | 275,729 | 14,687 | n.a. | (a) | 2,486,043 |
| | **25- 34** | 1,926,130 | 1,076,974 | 691,750 | 32,511 | 388,850 | 27,316 | 7,658 | (a) | 4,151,189 |
| | **35+** | 880,234 | 507,193 | 295,373 | 24,986 | 157,906 | 11,662 | 3,446 | (a) | 1,880,799 |
| | **Total** | 4,630,501 | 2,465,059 | 1,741,477 | 69,283 | 996,291 | 64,397 | 13,245 | (a) | 9,980,252 |
| **2000-01** | **< 20** | 712,296 | 307,408 | 303,590 | 4,515 | 184,963 | 14,025 | 1,522 | (a) | 1,528,320 |
| | **20- 24** | 1,171,763 | 583,139 | 466,745 | 5,305 | 275,954 | 13,669 | 1,805 | (a) | 2,518,379 |
| | **25- 34** | 2,019,984 | 1,076,620 | 748,644 | 32,161 | 426,137 | 25,150 | 6,447 | (a) | 4,335,142 |
| | **35+** | 935,072 | 533,231 | 320,524 | 24,350 | 182,073 | 12,185 | 3,382 | (a) | 2,010,818 |
| | **Total** | 4,839,114 | 2,500,398 | 1,839,502 | 66,332 | 1,069,126 | 65,029 | 13,156 | (a) | 10,392,657 |
| **2001-02** | **< 20** | 691,813 | 288,260 | 303,783 | 3,455 | 206,240 | 14,095 | 2,071 | (a) | 1,509,718 |
| | **20- 24** | 1,189,339 | 559,207 | 451,522 | 7,462 | 284,694 | 19,732 | 1,029 | (a) | 2,512,985 |
| | **25- 34** | 2,068,969 | 1,037,434 | 779,780 | 41,127 | 446,948 | 28,799 | 11,018 | (a) | 4,414,075 |
| | **35+** | 996,844 | 512,050 | 331,959 | 30,578 | 202,808 | 11,662 | 3,976 | (a) | 2,089,876 |
| | **Total** | 4,946,966 | 2,396,951 | 1,867,044 | 82,622 | 1,140,691 | 74,287 | 18,093 | (a) | 10,526,654 |
| **2002-03** | **< 20** | 694,403 | 270,977 | 304,362 | 3,217 | 193,230 | 27,585 | 2,290 | (a) | 1,496,064 |
| | **20- 24** | 1,132,840 | 529,971 | 465,383 | 6,410 | 264,972 | 34,454 | 1,316 | (a) | 2,435,346 |
| | **25- 34** | 1,987,048 | 996,015 | 752,478 | 38,550 | 419,457 | 48,179 | 7,206 | (a) | 4,248,933 |
| | **35+** | 987,238 | 540,874 | 335,201 | 32,417 | 183,634 | 22,695 | 3,883 | (a) | 2,105,943 |
| | **Total** | 4,801,529 | 2,337,838 | 1,857,424 | 80,593 | 1,061,293 | 132,914 | 14,695 | (a) | 10,286,286 |
| **2003-04** | **< 20** | 693,613 | 277,967 | 304,997 | 2,902 | 212,443 | 32,096 | 1,740 | (a) | 1,525,758 |
| | **20- 24** | 1,107,403 | 532,330 | 466,956 | 5,662 | 282,437 | 36,373 | 2,430 | (a) | 2,433,590 |
| | **25- 34** | 1,936,134 | 992,122 | 773,928 | 45,065 | 427,747 | 59,364 | 7,401 | (a) | 4,241,762 |
| | **35+** | 1,029,718 | 562,135 | 357,948 | 34,108 | 209,228 | 28,645 | 5,839 | (a) | 2,227,620 |
| | **Total** | 4,766,867 | 2,364,554 | 1,903,830 | 87,737 | 1,131,854 | 156,479 | 17,410 | (a) | 10,428,730 |

(a) not available for confidentiality reasons - included in NSW.
n.a. not available for confidentiality reasons - included in totals.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-088

OUTCOME 2: Access to Medicare

Topic: ABORTION - MEDICARE ITEM 35500

Written Question on Notice

Senator Troeth asked:

Will the Minister for health advise why Medicare item 35500, which for years has been deemed appropriate to cover the first stage of a two-stage abortion procedure, has now been deemed inappropriate and removed from the schedule?

Answer:

Item 35500 has not been removed from the Medicare Benefits Schedule and the circumstances under which it can be claimed have not changed. Item 35500 is intended to cover those circumstances where the patient requires anaesthesia for the performance of a pelvic examination. It was never intended for use in the first stage of a two stage abortion.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-089

OUTCOME 2: Access to Medicare

Topic: ABORTION - LAMINARIA STENTS

Written Question on Notice

Senator Troeth asked:

Termination with laminaria stents is a longstanding method that is both safe and effective. Will the Minister for Health advise why there isn't a Medicare item specifically for the insertion of laminaria stents?

Answer:

The items in the Medicare Benefits Schedule that require the cervix to be dilated are intended to cover all aspects of the procedure, including the dilation, irrespective of how or by what method the cervix is dilated. Because of this, there is no need for a specific item for the insertion of laminaria stents.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-158

OUTCOME 2: Access to Medicare

Topic: ABORTION

Written Question on Notice

Senator Troeth asked:

Will the Minister for Health advise if he has instructed the Health Insurance Commission to investigate abortion clinics on this basis?

Answer:

The Minister for Health and Ageing has not instructed the Health Insurance Commission to investigate abortion clinics.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-090

OUTCOME 2: Access to Medicare

Topic: ABORTION - BILLING ARRANGEMENTS

Written Question on Notice

Senator Troeth asked:

With the change to billing arrangements stemming from the HIC audit of some abortion providers, will the Minister for Health advise how the Federal Government will ensure that a woman with an unplanned pregnancy who makes the difficult decision to terminate the pregnancy will be able to access affordable and confidential abortion services?

Answer:

The Medicare billing arrangements for abortion have not changed. It is not allowed that medical practitioners bulk bill the Health Insurance Commission (HIC) while at the same time charging their patient an out of pocket fee for the bulk billed service. The HIC has been investigating some providers for this practice in respect of termination of pregnancy items in the Medicare Benefits Schedule (MBS).

The items in the MBS will continue to be available for women who make the decision to terminate a pregnancy. The charge raised by providers for their services remains a matter for the provider and the patient and it is not possible to bulk bill while charging the patient an out of pocket fee.

The HIC has no information that suggests that fees for abortions have increased as a result of its action relating to clinics breaching the requirements of the *Health Insurance Act*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-091

OUTCOME 2: Access to Medicare

Topic: ABORTION CLINICS

Written Question on Notice

Senator Troeth asked:

In April 2004, Australian Birth Control Services (Sydney) was informed by the Health Insurance Commission that its Medicare rebate would no longer be paid because the $180 out-of-pocket theatre fee charged to patients contravened the Health Insurance Act. Australian Birth Control Services was forced to restructure its fees to keep services at the same price for patients.

The Abortion Providers Federations of Australia has confirmed that additional patient fee has been an almost universal practice among abortion providers, and changing that will increase the cost of terminations, making them less affordable and less accessible.

An increase in fees will put affordability of terminations out of reach of women in lower socio-economic status and could see a return to days prior to 1970, when poorer women had to access less safe services as they could not afford specialist costs. This has serious implications for the status of Australian women's reproductive health. In addition, if women are forced to save money to have a termination, this may result in women presenting at later stages in their pregnancy – therefore increasing the number of terminations performed in Australia at a later gestation and the accompanying risks to the woman's welfare.

Will the Minister for Health and Ageing advise if he has instructed the Health Insurance Commission to investigate abortion clinics on this basis.

Answer:

The Minister for Health and Ageing has not instructed the Health Insurance Commission (HIC) to investigate abortion clinics. The HIC has been investigating medical practitioners who may have contravened billing requirements under the *Health Insurance Act.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-092

OUTCOME 2: Access to Medicare

Topic: ABORTION

Written Question on Notice

Senator Troeth asked:

Will the Minister guarantee that women's access to safe and affordable termination services will not be undermined by the conduct or outcome of this investigation?

Answer:

The Health Insurance Commission (HIC) investigates medical practitioners who may be billing for Medicare services in breach of the *Health Insurance Act* (the Act).

The HIC has no information that suggests that fees for abortions have increased as a result of its action to investigate medical practitioners for possible breaches of the Act in respect of Medicare items for the termination of pregnancy. The items in the Medicare Benefits Schedule will continue to be available for women who make the decision to terminate a pregnancy, following consultation with their doctor.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-098

OUTCOME 2: Access to Medicare

Topic: ABORTION

Written Question on Notice

Senator Stott Despoja asked:

(a) Has the Department of Health and Ageing provided any information on the abortion issue to the Minister for Health within the last 12 months?

(b) If so, please provide details of this advice.

(c) If not, has the Department of health and ageing received any requests for information on the abortion issue from the Minister for Health within the last 12 months?

(d) If so please provide details of these requests.

Answer:

(a) Yes.

(b) Consistent with his portfolio responsibilities, the Minister has received information on a range of issues, including abortion.

(c) n/a

(d) n/a

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-204

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET

Written Question on Notice

Senator McLucas asked:

Can the department outline what data it collects about the safety net, and how periodically this data is collected?

Answer:

The department collects data on each medical service where a Medicare benefit or Medicare safety net benefit is paid. Data would include provider identification, de-identified patient data, Medicare Benefits Schedule item number, fee charged and benefit paid.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-205

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET

Written Question on Notice

Senator McLucas asked:

Can the department outline any information it collects regarding the pricing of services by specialists since the introduction of the safety net policy?

Answer:

The department collects data on the actual fees charged for each specialist medical service as described by a Medicare Schedule item number where a Medicare benefit or Medicare safety net benefit is paid.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-206

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET INCOME

Written Question on Notice

Senator McLucas asked:

Can the department provide a breakdown of safety net income claimed by specialist and electorate?

Answer:

A break down of the composition (including by specialist) of the costs of the safety net has been provided in answer to Senator McLucas' estimates question on notice number E05-208.

Details of Strengthening Medicare Safety Net benefits by Federal electoral division for the 2005 calendar year will be released in February 2006 as part of the annual release of Medicare data, including electorate breakdowns.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-207

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET

Written Question on Notice

Senator McLucas asked:

Is the department aware of any evidence of prices rising since the introduction of the safety net?

Answer:

Fees increase routinely each year to reflect changes in doctors' costs and updates to the Medicare Benefits Schedule (MBS). With the exception of assisted reproductive services, there appears to be no evidence of widespread general increases in fees charged across the MBS since the introduction of the extended Medicare safety net. The department is currently investigating increases in assisted reproductive service fees to determine whether these are the result of routine fee increases, transfer of costs between items or some other cause.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-208

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET

Written Question on Notice

Senator McLucas asked:

Since the Minister's separate announcement of a new Medicare benefit for obstetricians, can the department provide:

(a) The increase in claims against the item number since the introduction of the safety net? Is this a significant difference to the same time last year?

(b) How will these numbers affect the cost of the safety net? Has the department undertaken any modelling of the impact to the budget?

(c) Can the department provide a break down of the composition (eg. type of specialist or allied health professional) of the costs of the safety net? What share of the current estimates of the safety net come from obstetrics?

Answer:

(a) A new item 15999 for the planning and management of a pregnancy was introduced onto the Medicare Benefits Schedule (MBS) on 6 September 2004. To the end of January 2005 around 34,500 services had been claimed under item 15999. This is in line with expectations. It is not possible to compare these figures with previous years because there was no item for the planning and management of a pregnancy before 6 September 2004.

(b) Modelling since the introduction of the new obstetrics item 15999 indicates that the expenditure against the safety net as published at the time of the Pre-election Economic and Fiscal Outlook remains correct.

In August 2004 a change in the billing practices of obstetricians was noticed. Further analysis of the matter in cooperation with the medical profession found that charges for the planning and management of a pregnancy were being incorporated into the fees for antenatal consultations. Some of these fees related to the in-hospital component of the pregnancy.

A new item was introduced onto the MBS to make explicit the nature of these charges for the out-of-hospital management of the pregnancy beyond 20 weeks, also preventing any shifting of in-hospital charging to the new safety net. The new item cost $17 million, including $14 million in safety net benefits, to the end of December 2004.

(c) The table below provides a breakdown of Extended Medicare safety net expenditure by medical craft group for the period 12 March 2004 to 31 December 2004.

| **Peer Group** | **Column 1** | **Column 2** | **Column 3** |
|---|---|---|---|
| | **Safety Net expenditure 12 March 2004 to 31 December 2004** | **Total MBS expenditure 12 March 2004 to 31 December 2004** | **Safety Net expenditure as % of Total MBS expenditure** |
| General Practitioner (includes OMP) | $28,597,743 | $2,706,623,086 | 1.1% |
| Allied Health Practitioner | $297,968 | $169,945,731 | 0.2% |
| Anaesthetist (specialist and non-specialist) | $363,663 | $203,241,614 | 0.2% |
| Dermatologist | $3,454,603 | $77,926,065 | 4.4% |
| Diagnostic Imagist (specialist and non-specialist) | $18,011,124 | $962,982,428 | 1.9% |
| IVF Specialist | $22,216,053 | $75,577,834 | 29.4% |
| Obstetrician and Gynaecologists | $39,834,342 | $173,296,424 | 23.0% |
| Pathologist (specialist and non-specialist) | $4,220,432 | $1,153,842,383 | 0.4% |
| Physician | $12,799,790 | 813,710,796 | 1.6% |
| Psychiatrist | $9,848,278 | $169,359,613 | 5.8% |
| Radiation oncologist | $6,263,334 | $83,110,745 | 7.5% |
| Surgeon (specialist and non-specialist) | $19,180,067 | $730,466,706 | 2.6% |
| Other Medical Specialty | $1,351,048 | $37,457,905 | 3.6% |
| Total | $166,438,445 | $7,357,541,330 | 2.3% |

Based on date of claims processing

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-209

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET

Written Question on Notice

Senator McLucas asked:

On 23 August 2004, the Minister for Health released a press statement titled *Government works with Doctors on Operation of Safety net*. In this release the Minister mentioned that the department was talking with obstetricians and gynaecologists about the rise in the median fee charged for antenatal attendance. Can the department provide any detail on the nature and progress of these discussions?

Answer:

The department met with the representative body for obstetricians and gynaecologists on several occasions to discuss billing practices under the new safety net arrangements. As a result of these discussions a new item was introduced into the Medicare Benefits Schedule which provides for the planning and management of a pregnancy. This item (15999) commenced on 6 September 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-210

OUTCOME 2: Access to Medicare

Topic: MEDICARE SAFETY NET

Written Question on Notice

Senator McLucas asked:

Can the department provide any insight into the additional funding revealed in the PEFO - which was explained as a 'parameter variation'?

(a) What were the department's original estimates with regards to registration levels?

(b) Please provide a breakdown of the increase in registrations and costs which underpin this 'parameter variation'

Answer:

Page 7 of the Pre-Election Economic and Fiscal Outlook (PEFO) 2004 states that there was a parameter or other variation for:

> "a $142 million increase in expenses relating to the Medicare Safety Net, due to higher estimated rates of family registration and out-of-pocket costs."

In July/August 2004 the Department of Health and Ageing reviewed the Extended Medicare Safety Net estimates having regard to:

- New Medicare claims data showing growth in average out-of-pocket costs between 2001 and 2003 (prior to the introduction of the safety net);
- The impact of advertising and promotion of the safety net on the rates of family registration and substantiation of claims; and
- The impact of changes in the billing pattern of obstetricians.

(a) The department's original modelling assumed that 67% of the full potential cost of the safety net would be realised, based on historical rates of family registration for the safety net and substantiation of out-of-pocket costs. In the revised modelling this was raised to 95-98% across each cohort of patients sorted by the level of out-of-pocket costs.

(b) Of the $142 million variation to the 2004-05 forecast expenditure under the safety net, the department estimates that:

- 34% ($48 million) results from the increase in registration and substantiation rates;
- 27% ($39 million) results from the new data on out-of-pocket costs between 2001 to 2003; and
- 39% ($55 million) is for the inclusion of pre-existing obstetric charges billed outside the Medicare system prior to the new safety net and unknown when the original costing was done.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-170

OUTCOME 2: Access to Medicare

Topic: MEDICARE BENEFITS SCHEDULE ELIGIBLE MAGNETIC RESONANCE IMAGING (MRI)

Written Question on Notice

Senator McLucas asked:

At what stage in the process is there a consideration of the ability of the population in a given area to access Medicare rebateable services?

Answer:

The ability of a population to access Medicare rebateable MRI services was a consideration in the recent MRI expansion. The process targeted specific geographical areas that had significant population bases but did not have access to Medicare eligible MRI services. 21 units were funded through this process, including 17 of which were allocated to specific geographical areas which were under-serviced.

Eligibility was extended to these units on the basis that the provider could not re-locate their MRI unit without the agreement of the Australian Government. This condition had previously been a requirement for six units selected in 2001, and has also been extended to units that were made eligible in children's hospitals and as a result of election commitments (33 units in all).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-171

OUTCOME 2: Access to Medicare

Topic: MOBILE IMAGING SERVICES

Written Question on Notice

Senator McLucas asked:

For mobile imaging services such as X-rays which go to nursing homes etc and thus obviate the need for incapacitated patients to travel:

(a) Are patients able to get Medicare reimbursement for these services?

(b) Is the level of reimbursement the same as for stationary services?

(c) Is there any ability for the provider to be compensated by Medicare (or other government program) for the logistics and transport costs?

Answer:

(a) Yes, subject to the normal rules relating to the payment of Medicare benefits for diagnostic imaging services.

(b) Yes.

(c) No. There is currently no provision under the Medicare program for a provider to receive additional funding for logistics and transport costs associated with mobile imaging services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-172

OUTCOME 2: Access to Medicare

Topic: REIMBURSEMENT RATES FOR OLDER CT MACHINES

Written Question on Notice

Senator McLucas asked:

(d) Why does the Medicare reimbursement for CT scans vary with the age of the machine?

(e) How is this implemented?

Answer:

(a) A reduced Medicare benefit is paid for computed tomography (CT) services provided using equipment that is 10 years old or older. This is known as the capital sensitivity rule and was introduced in March 1999. The purpose of the rule is to promote appropriate practice and the use of up to date CT technology, and to ensure that the Australian Government does not continue to make a capital contribution to equipment that is already fully depreciated.

An exception to this rule applies to equipment located in remote areas.

(b) CT services listed in the Medicare Benefits Schedule are classified 'K' for scans performed on equipment that is under 10 years old and 'NK' for scans provided using the older equipment. Practices providing services using CT equipment that is 10 years old or older need to claim the 'NK' item unless they are in remote areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-173

OUTCOME 2: Access to Medicare

Topic: DIAGNOSTIC IMAGING MULTIPLE SERVICES RULES

Written Question on Notice

Senator McLucas asked:

Under what circumstances does Medicare only reimburse one of multiple scans conducted at the same time?

Answer:

The Health Insurance (Diagnostic Imaging Services Table) Regulations provide that Medicare would only reimburse one of multiple scans conducted at the same time under the following circumstances:

- a patient is provided two or more musculoskeletal ultrasound services on the same day;

- a Magnetic Resonance Imaging (MRI) (of the Head, Head and Cervical Spine, or Cardiovascular system) and a Magnetic Resonance Angiography service are performed on a single occasion. Only the MRI service is eligible for a reimbursement through Medicare.

The reason why Medicare reimburses for only one of these scans is that they can usually be performed at the same time using the same equipment and with minimal additional set-up costs for the diagnostic imaging provider.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-174

OUTCOME 2: Access to Medicare

Topic: ESSURE HYSTEROSCOPIC STERILISATION DEVICE

Written Question on Notice

Senator McLucas asked:

Essure has been funded by Medicare since 2001 but last year a decision was made by MSAC to discontinue this number on 1 May 2005. MSAC has asked for more data, which will not be available until sometime in 2007.

(a) Why was the decision made to ask for more data?

(b) Is there something about the current data provided (3.5 years worth) that indicates that Essure, which has been available on Medicare for 4 years, should not continue to be available?

(c) What is the current cost (per annum) to Medicare of this procedure?

Answer:

(a) The Medical Services Advisory Committee (MSAC) considered that further data were required in order to demonstrate the medium to longer term safety, effectiveness and cost effectiveness of the procedure. As a minimum, five years of data are usually required. This will not be available until 2006.

(b) It is not the government's usual practice to make Medicare benefits available for a procedure while it is being assessed by the MSAC. To do so would conflict with the government's policy that Medicare benefits are paid only for those treatments that are proven to be safe, effective and cost-effective.

However, Medicare benefits have been paid since April 2001 in relation to hysteroscopic sterilisation devices under a pre-existing MBS Item for hysteroscopy. The Minister has agreed that funding can continue until November 2007 to allow a further assessment by MSAC once more data are available.

(c) The Medicare Item Number that is used for hysteroscopic sterilization by tubal cannulation and placement of intrafallopian implant is 35633. This is one of a number of methods used in the performance of hysteroscopy that are claimed under this item. It is not possible to disaggregate these data.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-218

OUTCOME 2: Access to Medicare

Topic: SPECIALISTS WHO BULK BILL

Written Question on Notice.

Senator McLucas asked:

What will the government do to reward these specialists (eg pediatricians)?

Answer:

While the Australian Government is responsible for setting fees for Medicare benefits purposes, and for the payment of those benefits, it has no direct power or authority to determine the fees charged by doctors or their billing practices, nor can it compel them to observe the Medicare Benefits Schedule fee for a particular service.

The bulk billing facility is available to all doctors, including specialists. It is a matter for individual doctors to decide whether or not to use this arrangement.

At this stage the government is not considering any changes to Medicare to encourage specialists to bulk bill.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-219

OUTCOME 2: Access to Medicare

Topic: SPECIALISTS WHO BULK BILL

Written Question on Notice

Senator McLucas asked:

(a) OPSM has said that its optometrists in the ACT and Tasmania will no longer bulk bill. Is this likely to be extended to other states?

(b) What action will the department take to address this decision, given that it is in contravention of principles agreed when optometrists were first given access to Medicare?

Answer:

(a) It is the department's understanding that OPSM is conducting a trial in the ACT and Tasmania, involving its optometrists charging full Medicare Benefits Schedule fees rather than bulk billing. Pensioners, people on social security benefits, veterans and people under the age of 18 will continue to be bulk billed for eye examinations. The department is unaware of any plans to extend the trial to other states.

(b) The OPSM trial is not contravening any principles. Medicare pays benefits for consultations by optometrists under a Participating Agreement, whereby optometrists sign an undertaking to charge no more than the schedule fees for the services they perform. They have never undertaken to bulk bill. Nevertheless, in practice 96.6% of optometry services are bulk billed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-223

OUTCOME 2: Access to Medicare

Topic: BULK BILLING INCENTIVES - LONG CONSULTATIONS

Written Question on Notice

Senator McLucas asked:

(a) Is the department aware of the number of short vs long consultations since the bulk billing incentives were introduced? Can these numbers, before and after the policy changes, be provided?

(b) Please provide a breakdown of levels of GP consultations.

Answer:

(a) Yes.

(b) The table below shows the number of GP consultations in the 12 months prior to the introduction of the bulk billing incentives on 1 February 2004 and in the 12 months after their introduction.

| | 12 months ending 31 January 2004 | 12 months ending 31 January 2005 |
|---|---|---|
| Brief consultations | 1,405,901 | 1,368,718 |
| Standard consultations | 79,845,169 | 79,836,803 |
| Long consultations | 11,421,292 | 11,895,625 |
| Prolonged consultations | 1,291,906 | 1,337,404 |
| Total | 93,964,268 | 94,438,550 |

The consultation item groups shown in the table above account for over 95% of all unreferred GP attendances. The remainder of unreferred attendances include item groups such as the Enhanced Primary Care items, and Practice Incentive Program (PIP) incentive items.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-224

OUTCOME 2: Access to Medicare

Topic: BULK BILLING INCENTIVES

Written Question on Notice

Senator McLucas asked:

It was reported in March 2004 that the department had agreed it would conduct modelling on the impact of the incentives, to be completed by August.

(a) Has this modelling been done? If not, why not?

(b) What does it show? Can a copy be obtained?

Answer:

(a) & (b)

The department has not undertaken this modelling as there have been further significant changes to general practice financing through the Medicare Benefits Schedule since the government first introduced the bulk billing incentive in February 2004.

In May 2004, the bulk billing incentive was raised to $7.50 for services provided in regional, rural and remote areas, and in the whole of Tasmania.

In September 2004, GPs in eligible metropolitan areas with below average bulk billing rates and below average doctor-to-population ratios also became eligible for the $7.50 bulk billing incentive.

From 1 January 2005, the government increased the Medicare rebate for most GP services from 85% to 100% of the Medicare schedule fee and increased rebates for after-hours GP services. The government also introduced a new item for pap smears provided by a practice nurse on behalf of a GP in rural areas.

Further time is needed for sufficient uptake data to become available to enable a full analysis of the impact of these policy changes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-201

OUTCOME 2: Access to Medicare

Topic: PHARMACEUTICAL BENEFITS SCHEME (PBS) 12.5% PRICE REDUCTION POLICY

Written Question on Notice

Senator McLucas asked:

(a) What is the government's estimate of the percentage of PBS prescription medicines that will be dispensed at a price under the non-concessional co-payment following the implementation of the 12.5% pricing policy?

(b) What is the government's estimate of the percentage of PBS prescription medicines that will be dispensed at a price over the non-concessional co-payment following the implementation of the 12.5% pricing policy?

(c) What is the government's estimate of the percentage of PBS prescription medicines that will be dispensed at a price under the concessional co-payment following the implementation of the 12.5% pricing policy?

(d) What is the government's estimate of the percentage of PBS prescription medicines that will be dispensed at a price over the concessional co-payment following the implementation of the 12.5% pricing policy?

Answer:

(a) The Department of Health and Ageing does not collect data on the number of PBS prescriptions dispensed at a price which is less than the general co-payment amount (currently $28.60). As no PBS subsidy is payable for such prescriptions prior to patients reaching the PBS Safety Net, data on prescriptions in this category are not submitted to the Health Insurance Commission by pharmacists.

However, the Pharmacy Guild of Australia conducts a survey of a sample of pharmacists to estimate the numbers of prescriptions in this category.

In 2003-04 it was estimated that 26.3 million prescriptions were dispensed to general patients for PBS medicines that cost less than the general patient co-payment.

In the same period, 22.4 million prescriptions were dispensed to general patients for PBS medicines that cost more than the general patient co-payment (this figure does not include 5.5 million prescriptions for general patients dispensed after the PBS Safety Net threshold was reached).

The number of PBS prescriptions subsidised prior to safety net thresholds were reached for 2003-04 was 165.8 million (this figure does not include prescriptions for items below the general patient co-payment).

In January 2005, there were 48 PBS listings (88 brands) for which the dispensed price would change from being over the general co-payment to being under the general co-payment if a 12.5% price reduction were applied. The number of general patient prescriptions for these items in 2003-04 is estimated at around 1.4 million. These items would have accounted for around three per cent of total general patient prescriptions.

The 12.5% price reduction associated with the measure will occur only where a new brand is actually listed. The number of prescriptions where the dispensed price will change from being above to below the general co-payment amount will be dependent on: the number of new listings for medicines currently priced around the general co-payment amount; and the usage of those items.

The department has not estimated the proportions of scripts that will be affected in this way.

(b) The change in the number of prescriptions where the dispensed price is greater than the general co-payment amount of $28.60 will be dependent on the number of new listings where the 12.5% price reduction applies, and results in the dispensed price being under the co-payment amount as outlined under (a) above.

(c) Nil.

(d) The dispensed price for all listed PBS medicines is above the concessional co- payment amount. The pharmacist dispensing fee alone (currently $4.70) is above the concessional co-payment (currently $4.60). The dispensing fee is a component of the total dispensed price for each product listed on the PBS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-202

OUTCOME 2: Access to Medicare

Topic: PRICE REDUCTIONS FOR NEW BRANDS OF MEDICINE LISTED ON THE PHARMACEUTICAL BENEFITS SCHEME (PBS)

Written Question on Notice

Senator McLucas asked:

(a) What information regarding the 12.5% policy has been provided to foreign governments? Was this publicly available information or departmental briefing?

(b) Which foreign government's received this information? Please provide a list of countries.

(c) Did this involve overseas travel? If so provide a breakdown of costs including travel, accommodation and number of staff and their level.

Answer:

(a) The Minister for Health and Ageing received correspondence from two foreign governments in relation to the 12.5% price reduction required by government for listing new brands on the PBS. The Minister for Health and Ageing also met with government representatives from the United States Embassy in Australia about this issue. The information provided in all instances was based on publicly available information.

(b) The Embassy of France and the British High Commission wrote to the Minister for Health and Ageing on this issue. The Minister met with representatives from the United States Embassy. The United States Embassy also requested a meeting with the department for briefing and this was held on Thursday, 13 January 2005.

(c) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-203

OUTCOME 2: Access to Medicare

Topic: PRICE REDUCTIONS FOR NEW BRANDS OF MEDICINE LISTED ON THE PHARMACEUTICAL BENEFITS SCHEME (PBS)

Written Question on Notice

Senator McLucas asked:

(d) Will the revision to the 12.5% per cent policy appear in the May Budget?

(e) Is the Department of Health and Ageing aware of any impact this policy may have on the Australian pharmaceutical value chain – including manufacturers, wholesale distributors and pharmacists – and patient access to prescription medicines.

Answer:

(a) Yes, the 12.5% policy measure will be shown in the May Budget Paper No. 2 for 2005-2006 and the Department of Health and Ageing's 2005-2006 Portfolio Budget Statement.

(b) The department is aware that this policy will have some impact on manufacturers, wholesalers and pharmacies. The Australian Government has consulted with pharmaceutical industry groups, including Medicines Australia (representing pharmaceutical manufacturers), the Generic Medicines Industry Association (representing generic medicine manufacturers), the Pharmacy Guild of Australia (representing community pharmacies) and the National Pharmaceutical Services Association (representing pharmaceutical wholesalers) about this policy. Their views have been taken into account by the government.

Manufacturers - If a manufacturer wishes to list a new brand of a medicine already included on the PBS, they will need to offer a 12.5% price reduction to the price currently used for PBS subsidy purposes.

Pharmacies - The policy will also have an impact on pharmacies as a component of their remuneration from the Australian Government is linked to the price of PBS medicines through an allowance for retail mark up.

Wholesalers - The policy may have an impact on wholesalers. However, the extent of this impact will depend on the wholesale price of drugs and terms of trade negotiated between wholesalers and pharmacists.

Patients - Under PBS pricing policy, there will always be at least one brand of a medicine available for the PBS co-payment amounts. This will not change under this new policy. As is currently the case, manufacturers of other brands may choose to apply a brand premium to their products. Brand choice for consumers is an important part of the PBS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-101

OUTCOME 2: Access to Medicare

Topic: ENHANCED PRIMARY CARE (EPC)

Hansard Page: CA 7

Senator Moore asked:

(a) Would you be able to tell us how many EPC care plans are currently used or implemented?

(b) Can you tell us how many EPC care plans are now registered?

Answer:

(a) A total of 201,297 EPC care planning items have been claimed in the twelve month period January-December 2004.

(b) EPC care plans are not registered.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-102

OUTCOME 2: Access to Medicare

Topic: ALLIED HEALTH AND DENTAL CARE MEDICARE BENEFITS SCHEDULE ITEMS

Hansard Page: CA 8

Senator Moore asked:

(a) I am after the breakdown by allied health service of the number of services and the cost of those services, provided under EPC care plans

(b) I am also after the average number of services and the cost of those services and the cost of those services per patient

(c) Do you know what the out of pocket costs for patients who receive allied health services under EPC care plans are

Answer:

(a) (b) and (c)

In the six months to December 2004, a total of 84,094 allied and dental service claims were processed, with Medicare benefits amounting to $3.8 million.

Table 1 below provides details of these services including information on the number of patients, average number of services per patient, Medicare benefits paid, average Medicare benefits paid per patient and the average out-of-pocket cost per service by item number.

**Table 1.** Uptake of allied health and dental items in six months to December 2004 - by item number – including number of services and patients, benefits paid and out-of-pocket costs.

| Item number | Number of services | Number of patients* | Number of services per patient | Medicare Benefits paid | Average benefits per patient | Average out-of-pocket cost per service |
|---|---|---|---|---|---|---|
| 10950 ATSI health | 28 | 17 | 1.6 | $1,242.45 | $73.09 | N/A |
| 10951 Diabetes education | < than 10** | < than 10 | 1.0 | $268.75 | $44.79 | $0.04 |
| 10952 Audiology | 60 | 51 | 1.2 | $2,924.45 | $57.34 | $22.06 |
| 10954 Dietitics | 15,319 | 9,222 | 1.7 | $683,968.85 | $74.17 | $11.15 |
| 10956 Mental health | 158 | 65 | 2.4 | $8,672.25 | $133.42 | $21.93 |
| 10958 Occupational therapy | 393 | 173 | 2.3 | $18,970.15 | $109.65 | $16.44 |
| 10960 Physiotherapy | 40,318 | 12,663 | 3.2 | $1,791,439.50 | $141.47 | $3.91 |
| 10962 Chiropody/Podiatry | 13,303 | 9,217 | 1.4 | $588,027.50 | $63.80 | $3.88 |
| 10964 Chiropractic | 3,928 | 1,152 | 3.4 | $168,108.85 | $145.93 | $2.74 |
| 10966 Osteopathy | 1,634 | 532 | 3.1 | $73,227.20 | $137.65 | $7.85 |
| 10968 Psychology | 7,115 | 2,695 | 2.6 | $356,434.05 | $132.26 | $32.28 |
| 10970 Speech pathology | 682 | 211 | 3.2 | $33,329.70 | $157.96 | $11.75 |
| 10975 Dental assessment | 516 | 516 | 1.0 | $39,736.20 | $77.01 | $33.34 |
| 10976 Dental treatment | 626 | 450 | 1.4 | $69,625.45 | $154.72 | $68.62 |
| 10977 Dental assessment or treatment by dental specialist | < than 10 | < than 10 | 1.0 | $593.80 | $74.23 | $35.79 |
| Total | 84,094 | 32,419 | 2.59 | $3,836,569.15 | $118.34 | $9.09 |

* The number of patients is not additive across item types as the same patients claim multiple item types.
** Diabetes education services (10951) commenced on 1 November 2004

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-103

OUTCOME 2: Access to Medicare

Topic: PRACTICE INCENTIVES PROGRAM

Hansard Page: CA 10

Senator Moore asked:

(a) How many practices are signed up for the various practice incentive program activities?
(b) Can we get a breakdown of numbers and percentages by activity?
(c) Can we get a breakdown of payments by activity?
(d) Is it possible to get an average payment by activity by participating practice?

Answer:

(a) (b) (c) and (d)

**PRACTICE INCENTIVES PROGRAM - practice payments only**

| 2003 - 2004<br>Activity | Number practices participating - May 2004 | Percentage of eligible practices | Total annual payment $ | Average payment per practice $ |
|---|---|---|---|---|
| IM/IT Tier 1 | 4646 | 100% | 40,066,922 | 8,624 |
| Electronic prescribing (IM/IT Tier 2) | 4274 | 92% | 25,231,111 | 5,903 |
| Data connectivity (IM/IT Tier 3) | 4228 | 91% | 25,051,448 | 5,925 |
| Ensuring patient access to 24 hour care (After hours Tier 1) | 4507 | 97% | 26,293,305 | 5,834 |
| Provision of at least 15 hours of after hours care from within the practice (After hours Tier 2) | 3159 | 68% | 20,105,328 | 6,364 |
| Providing all after hours care for practice patients (After hours Tier 3) | 1347 | 29% | 7,895,000 | 5,860 |

| 2003 - 2004<br>Activity | Number practices participating - May 2004 | Percentage of eligible practices | Total annual payment $ | Average payment per practice $ |
|---|---|---|---|---|
| Teaching | 518 | 11% | 2,639,950 | 2,064 |
| Quality Prescribing Incentive | 1208 | 26% | 3,192,097 | 2,643 |
| Procedural GP (RRMA 3-7)<br>*Commenced in May 04* | 291 | 21% | 740,000 | 2,601 |
| Practice Nurses<br>*Extended to RRMA 1-2 in May 04* | 1475 | 59% | 22,955,741 | 18,461 |
| Cervical Screening Outcomes | 881 | 21% | 2,843,124 | 3,227 |
| Diabetes Outcomes | 1689 | 41% | 5,856,910 | 3,468 |
| Rural loading (RRMA 3-7) | 1355 | 100% | 19,903,446 | 14,689 |
| **Total** | **4646** | **100%** | **202,774,382** | **43,645** |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-104

OUTCOME 2: Access to Medicare

Topic: PRACTICE INCENTIVES PROGRAM - SERVICE INCENTIVE PAYMENTS

Hansard Page: CA 10

Senator Moore asked:

(a) Can we have a breakdown of service incentive payments by activity?

(b) We are also interested in the kind of averaging as well, so the particular wording is: an average service incentive payment, by activity per participating practice.

Answer:

(a) and (b)

**Practice Incentives Program - Service Incentive Payments (SIPs)**

**2003-2004**

| **Activity** | **Number of SIPs** | **Incentive payments** | **Average SIP payments per practice** |
|---|---|---|---|
| Asthma - Completion of the requirements of the Asthma 3+ Visit Plan | 25,694 | $ 2,569,400 | $ 610 |
| Cervical Screening - taking of a cervical smear from a woman between the ages of 20 and 69 inclusive, who has not had a cervical smear for 4 years | 51,545 | $ 1,804,075 | $ 431 |
| Diabetes - completion of an annual cycle of care for a patient with established diabetes mellitus | 113,299 | $ 4,531,960 | $ 1,102 |
| 3 Step Mental Health Process* | 13,908 | $ 2,086,200 | $ 599 |

* 3 Step Mental Health Process participation is on a GP basis

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-105

OUTCOME 2: Access to Medicare

Topic: GENERAL PRACTICE IMMUNISATION INCENTIVES (GPII) SCHEME

Hansard Page: CA 10

Senator Moore asked:

One particular comment we want to know about is on the reasons, if you can get them, why service incentive payments under the GP immunisation scheme went down. Is there any kind of awareness of why that happened?

Answer:

Under the GPII Scheme, general practitioners receive a Service Incentive Payment if they notify the Australian Childhood Immunisation Register of a vaccination that completes an immunisation schedule, according to the National Immunisation Program.

Prior to September 2003, there were six milestones (or schedules) at which children should be vaccinated: 2 months; 4 months; 6 months; 12 months; 18 months; and 4 years. In September 2003, the National Health and Medical Research Council recommended that the 18 month dose of triple antigen (Diphtheria, Tetanus, Pertussis) was no longer required.

Therefore, the removal of the 18 month schedule also removed a Service Incentive Payment point for general practitioners. This resulted in a decrease in Service Incentive Payments made under the GPII Scheme in 2003-04. Payments decreased by $2.7 million in the 2003-04 financial year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-106

OUTCOME 2: Access to Medicare

Topic: COMPREHENSIVE MEDICAL ASSESSMENT

Hansard Page: CA 16

Senator Moore asked:

(a) Does the department have any statistics about how many GPs have actually used the CMA rebate?

(b) When the program was introduced, were some goals put in place that by a certain amount you would have so many practices using it and so many tests done?

(c) Is the projection information public?

(d) Do you have information about how many you wanted to have done in the first year?

(e) Is that a public document?

Answer:

The Medicare item for Comprehensive Medical Assessments (CMAs) came into effect on 1 July 2004.

(a) 1,635 medical practitioners have provided CMAs in the period 1 July to 31 December 2004.

(b) Yes. There were estimates of the number of CMAs that would be provided over four years to 2007-08. Goals were not set for the number of practices using this item.

(c) The projection information has not been made public.

(d) It was estimated that around 20,000 CMA services would be provided in the first year.

(e) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-139

OUTCOME 2: Access to Medicare

Topic: PBS SCRIPTS

Hansard Page: CA 27

Senator Barnett asked:

Please provide ten years worth of data split by state on:

i. The average number of PBS scripts per person per annum.
ii. The average government cost per PBS script per annum.

Answer:

The requested data are set out in the following tables. The data only relates to the Pharmaceutical Benefits Scheme (PBS) and has been calculated on a cash accounting basis. Repatriation Pharmaceutical Benefits Scheme data are not included. The data does not include PBS prescriptions for general patients which cost less than the general co-payment amount – so-called under-co-payment items – for which the consumer pays the actual cost and there is no government subsidy involved. These prescriptions are estimated to represent about 15% of PBS scripts.

**i. Average Number of PBS Scripts Per Person Per Annum**

| Year | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | AUSTRALIA |
|---|---|---|---|---|---|---|---|---|---|
| **1994/95** | 7.0 | 6.5 | 6.1 | 7.3 | 5.5 | 7.6 | 2.2 | 4.1 | 6.5 |
| **1995/96** | 7.3 | 6.8 | 6.4 | 7.6 | 5.7 | 7.9 | 2.3 | 4.3 | 6.8 |
| **1996/97** | 7.2 | 6.7 | 6.3 | 7.4 | 5.6 | 7.8 | 2.3 | 4.2 | 6.7 |
| **1997/98** | 7.2 | 6.6 | 6.4 | 7.4 | 5.6 | 7.8 | 2.3 | 4.3 | 6.7 |
| **1998/99** | 7.2 | 6.8 | 6.5 | 7.5 | 5.8 | 7.9 | 2.4 | 4.6 | 6.8 |
| **1999/00** | 7.6 | 7.2 | 6.9 | 7.9 | 6.1 | 8.4 | 2.4 | 4.9 | 7.2 |
| **2000/01** | 8.0 | 7.8 | 7.5 | 8.5 | 6.7 | 8.9 | 2.6 | 5.4 | 7.7 |
| **2001/02** | 8.2 | 8.0 | 7.7 | 8.7 | 7.0 | 9.4 | 2.6 | 5.6 | 7.9 |
| **2002/03** | 8.3 | 8.1 | 7.6 | 8.9 | 7.1 | 9.5 | 2.7 | 5.8 | 8.0 |
| **2003/04** | 8.5 | 8.4 | 7.9 | 9.1 | 7.3 | 9.8 | 2.8 | 6.0 | 8.2 |

## ii. Average Government Cost Per PBS Script Per Annum

| Year | NSW | VIC | QLD | SA | WA | TAS | NT | ACT | AUSTRALIA |
|---|---|---|---|---|---|---|---|---|---|
| **1994/95** | $16.37 | $15.77 | $15.60 | $15.37 | $15.76 | $15.57 | $14.75 | $18.03 | $15.94 |
| **1995/96** | $18.03 | $17.49 | $17.35 | $17.09 | $17.52 | $17.13 | $16.71 | $20.02 | $17.64 |
| **1996/97** | $19.35 | $18.76 | $18.47 | $18.34 | $18.72 | $18.30 | $17.91 | $21.70 | $18.90 |
| **1997/98** | $20.70 | $20.26 | $19.86 | $19.78 | $20.02 | $19.56 | $19.87 | $23.38 | $20.30 |
| **1998/99** | $22.11 | $21.65 | $21.27 | $20.99 | $21.40 | $20.67 | $22.46 | $24.62 | $21.69 |
| **1999/00** | $23.45 | $23.24 | $22.54 | $22.44 | $22.71 | $22.31 | $23.64 | $25.97 | $23.08 |
| **2000/01** | $26.20 | $25.83 | $25.42 | $25.13 | $25.70 | $24.80 | $26.19 | $28.75 | $25.82 |
| **2001/02** | $27.39 | $27.26 | $26.64 | $26.61 | $26.97 | $25.77 | $27.92 | $29.76 | $27.10 |
| **2002/03** | $29.04 | $29.18 | $28.41 | $28.52 | $28.62 | $27.21 | $29.12 | $31.47 | $28.86 |
| **2003/04** | $30.34 | $30.25 | $29.97 | $30.00 | $30.01 | $28.71 | $30.72 | $32.71 | $30.17 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-242

OUTCOME 2: Access to Medicare

Topic: GENERAL PRACTICE PARTNERSHIPS ADVISORY COUNCIL (GPPAC) PROJECT ON THE MEASUREMENT AND REWARD OF QUALITY GP CARE

Hansard Page: CA 47

Senator Moore asked:

One of the things that we are interested in is the work that had been commenced on the measurement and reward of quality GP care. We were of the belief that that was something GPPAC were doing. Is it your understanding that there was a project looking at the measurement of quality care?

Answer:

In December 1999, GPPAC commissioned the Newcastle Institute of Public Health and Hunter Area Health Service consortium (under the auspice of the University of Newcastle) to develop a set of quality indicators for Australian general practice.

The Newcastle Institute of Public Health was selected via a competitive tender process.

A report entitled, *Evidence-based indicators for improving the quality of health care provision in General Practice*, and dated *Final Report November 2000*, was delivered to the Quality Consultancy Steering Committee in December 2000.

The department's understanding is that the report was not endorsed by GPPAC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-161

OUTCOME 2: Access to Medicare

Topic: HEALTH*CONNECT* AND PATENTS

Hansard Page: CA 59

Senator Forshaw asked:

With regard to Health*Connect* and patents, I understand it was recently reported that the department was not aware that the Pharmacy Guild had requested a formal examination of a patent application. I understand the patent application was lodged by a CR consultancy, or IP Australia.

Answer:

The department has been aware of this issue since the Pharmacy Guild first lodged its application in 2003.

The guild's subsidiary, CR Group, has also lodged a patent application for a related 'invention'. In December 2004, the guild and CR Group formally requested examinations of their applications.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-149

OUTCOME 2: ACCESS TO MEDICARE

Topic: UPTAKE OF ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH CHECK

Hansard Page: CA 67 - 68

Senator McLucas asked:

(a) Do you have any idea what proportion of the potential population are eligible for the Aboriginal and Torres Strait Islander Adult Health Check item?

(b) You say it is a comprehensive health item. What does that mean?

Answer:

a) To December 2004, a total of 4,577 claims have been paid through Medicare for Aboriginal and Torres Strait Islander adult health checks. This represents approximately 1.8% of the estimated eligible population (Aboriginal and Torres Strait Islander people aged 15 to 54 years).

b) An Aboriginal and Torres Strait Islander Adult Health Check is a comprehensive health check that must include:

1. taking the patient's medical history;
2. examining the patient;
3. undertaking or arranging any required investigation;
4. assessing the patient using the information gained in the health check; and
5. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

A full description of an adult health check service is included in the Medicare Benefits Schedule book (1 November 2004, pp 38-40) see Attachment A. This information is also available through the department's website www.health.gov.au/atsiinfo.htm)

| ENHANCED PRIMARY CARE | ENHANCED PRIMARY CARE |
|---|---|
| | **GROUP A14 - HEALTH ASSESSMENTS** |
| H<br>710 | ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH CHECK<br>Attendance by a medical practitioner, other than a specialist or a consultant physician, at consulting rooms or in another place other than a hospital or Residential Aged Care Facility, for an adult health check of a patient who is of Aboriginal or Torres Strait Islander descent and aged at least 15 years old and less than 55 years old - not being an adult health check of a patient in respect of whom, in the preceding 18 months, a payment has been made under this item<br>**Fee:** $191.65 **Benefit:** 75% = $143.75 85% = $162.95 |

**A.20.16 Aboriginal and Torres Strait Islander Adult Health Check (Item 710)**

The purpose of this adult health check is to ensure that Aboriginal and Torres Strait Islander people receive the optimum level of health care by encouraging early detection, diagnosis and intervention for common and treatable conditions that cause considerable morbidity and early mortality.

This item applies to an Aboriginal and/or Torres Strait Islander person who is at least 15 years old and less than 55 years old. It complements the existing voluntary annual health assessment, available to Aboriginal and Torres Strait Islander people aged 55 years and over.

The major causes of excess mortality in this population are:

- circulatory conditions (including ischaemic heart disease, hypertension, cerebrovascular disease and rheumatic heart disease);
- external causes (including accidents, injury to self and others, and the sequelae of substance use);
- respiratory conditions (related to infection and to tobacco use); and
- endocrine causes (mainly type two diabetes and its complications).

Cervical cancer remains a significant cause of death in this under-screened population.

Causes of morbidity vary but include the risk factors and precursors of all the above. They also include infections of the respiratory system, the ears (in particular, Chronic Suppurative Otitis Media), the eyes (trachoma in some settings) the skin and the gastrointestinal system. End-stage renal disease is a major cause of hospitalisations, and much early renal disease remains undetected. In some settings, sexually transmissible infections are particularly common.

Living environments may be compromised by one or more of the following – overcrowding, limited access to clean water and sanitation, and poverty. In addition to the usual spectrum of mental disorder, social and family life may be negatively influenced by an excessive burden of care for family members, by substance use and sometimes by family violence.

**A.20.17** An Aboriginal and Torres Strait Islander Adult Health Check means the assessment of an Aboriginal and/or Torres Strait Islander patient's health and physical, psychological and social function, and whether preventive health care, education and other assistance should be offered to that patient, to improve the patient's health and physical, psychological or social function.

**A.20.18** This item does not apply to people who are in-patients of a hospital, day hospital facility or care recipients in a residential aged care facility. Practitioners should consider the applicability of other medical services, including other Enhanced Primary Care services, to ensure that the health needs of eligible patients as identified in the health check are followed up.

**A.20.19** For the purposes of this item a person is an Aboriginal and/or Torres Strait Islander person if the person identifies himself or herself as being of Aboriginal and/or Torres Strait Islander descent. Patients should be asked to self-identify their Aboriginal and/or Torres Strait Islander status and their age for the purpose of these items, either verbally or by completing a form.

**A.20.20** The Aboriginal and Torres Strait Islander adult health check should generally be undertaken by the patient's 'usual doctor', that is the medical practitioner, or a practitioner working in the medical practice or health service, who has provided the majority of services to the patient in the past twelve months, or who will provide the majority of services in the following twelve months.

Before the health check is commenced, the patient must be given an explanation of the health check process and its likely benefits, and must be asked by the medical practitioner whether they consent to the health check being performed. Consent must be noted on the patient record.

When a medical practitioner undertakes a health check for an Aboriginal and/or Torres Strait Islander person, he or she should consider the results of any previous consultations and health checks for that person. It may therefore be appropriate to obtain and consider the patient's relevant medical records, where these are available, before undertaking the health check.

**A.20.21**.....The information collection component of the assessment may be completed by an Aboriginal/Torres Strait Islander health worker, nurse or other qualified health professional where:

(a) the patient's medical practitioner has initiated the collection of information by a third party, after the patient has agreed to the Adult Health Check and has agreed to a third party collecting information for the assessment;
(b) the patient is told whether or not information collected about them for the health check will be retained by the third party; and
(c) the third party acts under the supervision of the practitioner.

The other components of the health check must include a personal attendance by the medical practitioner.

**A.20.22** The medical practitioner should:
(a) be satisfied that the person collecting information for the Adult Health Check has the necessary skills, expertise, training and cultural awareness;
(b) have established how the information is to be collected and recorded (including any forms used);
(c) set or approve the quality assurance procedures for the information collection;
(d) be consulted on any issues arising during the information collection; and
(e) review and analyse the information collected to prepare the report of the health check and communicate to the patient their recommendations about matters covered by the health check.

**A.20.23** An Aboriginal and Torres Strait Islander Adult Health Check must include:

(a) taking the patient's medical history;
(b) examining the patient;
(c) undertaking or arranging any required investigation;
(d) assessing the patient using the information gained in the health check; and
(e) making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

### A.20.24 History

The health check must include the taking of a comprehensive patient medical history (if one does not already exist) or the updating of that history (if it already exists). This should include recording personal information relating to the patient – name, age and gender. It is also recommended that contact details are updated at each appointment and that alternative contact details for the patient are recorded.

Mandatory matters:

(a) medical history, current health problems and health risk factors;
(b) relevant family medical history;
(c) medication usage – including OTC and medication from other doctors;
(d) immunisation status (refer to the appropriate current age and sex immunisation schedule);
(e) sexual and reproductive health;
(f) physical activity, nutrition and alcohol, tobacco or other substance use;
(g) hearing loss;
(h) mood (depression and self-harm risk); and
(i) family relationships and whether the patient is a carer or is cared for by another person.

Optional, as indicated for the patient:

(a) visual acuity (recommended for people over 40);
(b) work status (eg paid/unpaid work, Community Development Employment Projects, in training or education);
(c) environmental and living conditions;
(d) other history as considered necessary by the practitioner/collector.

### A.20.25 Examination

Mandatory matters:

(a) measurement of the patient's blood pressure, pulse rate and rhythm;
(b) measurement of height and weight to calculate BMI, and, if indicated, measurement of waist circumference for central obesity;
(c) oral examination (gums and dentition);
(d) ear and hearing (otoscopy and, if indicated, a whisper test); and
(e) urinalysis (dipstick) for proteinurea.

Optional, as indicated for the patient:

(a) reproductive and sexual health examination;
(b) trichiasis check where indicated;
(c) skin examination;
(d) visual acuity (recommended for all aged over 40 ); and
(e) other examinations considered necessary by the practitioner.

### A.20.26 Investigations as required

Arrange or undertake investigations as clinically indicated, considering the need for the following tests, in particular, in accordance with national or regional guidelines or specific regional needs:

(a) fasting blood sugar and lipids (laboratory based test on venous sample) but random blood glucose levels if necessary;
(b) pap smear;
(c) STI testing (urine or endocervical swab for chlamydia/gonorrhoea, especially for those aged 15-35 years);
(d) mammography, where eligible (by scheduling appointments with visiting services or facilitating direct referral); and
(e) other investigations considered necessary by the practitioner, in accordance with current recommended guidelines.

Practitioners should ensure that the results of investigations undertaken for the health check are followed up, consistent with good clinical practice.

### A.20.27 Assessment of patient

The overall assessment of the patient, including the patient's level of cardiovascular risk, must be based on consideration of evidence from patient history, examination and results of any investigations. Note that if tests have been ordered but results are not yet available, the practitioner may choose to either complete the health check and review the test results as opportunity arises in a subsequent consultation, or defer completion of the health check until the results are available. In either case the practitioner should ensure that any test results are reviewed and followed up as necessary.

### A.20.28 Intervention

As part of the health check the practitioner must initiate intervention activity which he or she considers necessary to meet the identified needs of the patient.

The practitioner must assess risk factors and should discuss those risk factors with the patient. The practitioner should provide or arrange for preventive health advice and intervention activity as indicated (including arranging for activity and services by other local health and care providers). This may include:

(a) initiation of treatment, referral and/or immunisation;
(b) education, advice and/or assistance in relation to smoking, nutrition, alcohol / other substance use, physical activity (SNAP), reproductive health issues eg pre-pregnancy education/ counselling, safer sex and/or social and family issues; and
(c) other interventions considered necessary by the practitioner.

The practitioner must develop a simple strategy for good health for the patient, including identification of required services and actions the patient should take, based on information from the health check. It should take account of any relevant previous advice given to the patient and the outcome of that advice. The strategy for good health should be developed in collaboration with the patient and must be documented in the report about the health check.

**A.20.29** The health check must also include keeping a record of the health check, and offering the patient a written report about the health check, with recommendations about matters covered by the health check, including a simple strategy for the good health of the patient.

In circumstances where the patient's usual practitioner or practice has not undertaken the health check, a copy of the health check report should be forwarded to that medical practitioner or practice, with the patient's consent.

**A.20.30** It is recommended that practitioners establish a register of their patients seeking a two yearly health check and remind registered patients when their next health check is due.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-150

OUTCOME 2: ACCESS TO MEDICARE

Topic: UPTAKE OF ABORIGINAL AND TORRES STRAIT ISLANDER ADULT HEALTH CHECK

Hansard Page: CA 67 - 68

Senator McLucas asked:

Please provide a one page description of what is covered by the Adult Check Item.

Answer:

An Aboriginal and Torres Strait Islander Adult Health Check is a comprehensive health check that must include:

1. taking the patient's medical history;
2. examining the patient;
3. undertaking or arranging any required investigation;
4. assessing the patient using the information gained in the health check; and
5. making or arranging any necessary interventions and referrals, and documenting a simple strategy for the good health of the patient.

A full description of an adult health check service is included in the Medicare Benefits Schedule book (1 November 2004, pp38-40) see E05-149 - Attachment A. This information is also available through the department's website www.health.gov.au/atsiinfo.htm)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-244

OUTCOME 2: ACCESS TO MEDICARE

Topic: NATIONAL GUIDE TO A PREVENTIVE HEALTH ASSESSMENT IN ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES

Hansard Page: CA 68

Senator McLucas asked:

I understand there is a guide that has been developed for preventative health assessments, a substantial guide developed through the Royal Australian College of General Practice (RACGP).

a) Has that been published?

b) Was it provided to the department by the RACGP in February 2003

Answer:

a) No.

b) While an early draft of the National Guide was provided in February 2003, the RACGP presented its final draft following editing and endorsement on 31 August 2004. Comments on this draft have been provided to the RACGP, who are currently making further refinements to the National Guide. The department anticipates that this work will be concluded soon, enabling distribution of the completed guide by mid-2005.