# Community Affairs
# Legislation Committee

## Examination of Additional Estimates 2002-2003

## Additional Information Received

## VOLUME 3

**Outcomes: 4, 5, 7, 8, 9**

## HEALTH AND AGEING PORTFOLIO

**MAY 2003**

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 2002-2003

Included in this volume are answers to written and oral questions taken on notice relating to the additional estimates hearings on 13 February 2003

# HEALTH AND AGEING PORTFOLIO

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-160

OUTCOME 4: QUALITY HEALTH CARE

Topic: AFTER HOURS GP PILOT PROGRAMS

Written Question on Notice

Senator McLucas asked:

(a) Can the Department advise the full list of people who received letters from the previous Minister in late 2001 advising them that they had been granted funding under the After Hours GP service program?
(b) How many of these projects are now operational and how many are still undertaking preparation for implementation?
(c) How much has been paid out so far of the $43 million promised?
(d) What is the next stage in development of this initiative and what steps will be taken to involve the States and other potential groups interested in organising after hours GP services?

Answer:

(a) A list of the organisations that received letters in 2001 advising grant funding in the first round of the After Hours Primary Medical Care (AHMPC) Development Grants Program follows:

| **Auspicing Body** | **Area** | **State** |
|---|---|---|
| **SEEDING GRANTS** | | |
| Rockingham Kiwinana Division of GP | Rockingham | WA |
| N.E. Valley Division of General practice Ltd | North East Melbourne | VIC |
| St Andrews Toowoomba Hospital | Toowoomba | QLD |
| Central Australian Division of Primary Health Care Inc | Alice Springs | NT |
| General Practice Division of Northern Territory Inc | Maningrida,Jabinu, Oenpelli | NT |
| General Practice Divisions Northern Territory Inc | Darwin | NT |
| Swan Hills Division of General Practitioners Ltd | Kalamunda | WA |
| Bundaberg & District Division of GP Assoc Inc | Wide Bay Region | QLD |
| Central Wheatbelt Division of GP Inc | Central Wheatbelt | WA |
| Dandenong District Division of GP Inc | Dandenong | VIC |
| Central Highlands Division of GP Ltd | Greater Macedon Ranges | VIC |
| GP Education Austalia Ltd | AMDS Education Program | VIC |
| Hunter Rural Division of GP Ltd | Hunter Rural area | NSW |
| Western Sydney Division of GP | Mt Druitt area | NSW |
| Queensland Health - QEII Hospital Health Service District | South Brisbane | QLD |
| Greater Bunbury Division of GP | Bunbury | WA |
| Port Macquarie Division of GP Ltd | Port Macquarie area | NSW |

| | | |
|---|---|---|
| Latrobe Community Health Service | Gippsland | VIC |
| Melbourne Health | North West Melbourne | VIC |
| Assoc of the Brisbane Inner South Division of GP Inc | Brisbane South | QLD |
| Wollongong Medical Service Co-op Ltd | Wollongong | NSW |
| SA Divisions of GP Inc | South Australia | SA |
| Calvary Health Care Riverina Inc | Wagga Wagga | NSW |
| South East NSW Division of General Practice Ltd | South East NSW | NSW |
| ACT Division of General Practice Ltd | ACT | ACT |
| North Eastern Victorian Dvision of General Practice Ltd | North East Victoria | VIC |
| Western Health Victoria | West Melbourne | VIC |
| RFDS South East Sector | Western NSW | NSW |
| Assoc of Bayside GP Division Brisbane Inc | Bayside & District | QLD |
| Mackay Division of General Practice Ltd | Mackay district | QLD |
| Ipswich & West Moreton Division of General Practice | Ipswich | QLD |
| RACGP WAS Research Unit | Fremantle | WA |
| Far West Area Health Service | Broken Hill | NSW |
| Knox Division of GP Ltd | Knox | VIC |
| Bendigo & District Division of GP | Bendigo | VIC |
| Mid North Coast (NSW) Division of GP Ltd | Mid North Coast | NSW |
| The Rural Doctors Workforce Agency Inc | Rural & Remote SA | SA |
| Hornsby Ku-rin-gai Ryde Division of GP Ltd | Hornsby | NSW |
| **INFRASTRUCTURE GRANTS** | | |
| Goulburn Valley Division | Shepparton | VIC |
| Sunshine Coast Division of GP Assoc Ltd | Gympie | QLD |
| **SERVICE DEVELOPMENT GRANTS** | | |
| Central Coast Division of GP Inc | Erina | NSW |
| Whitehorse Division of GP Inc | Eastern Suburbs | VIC |
| The Uniting Church in Australia Property Trust (Q) trading as the Sunshine Coast Private Hospital | Sunshine Coast | QLD |
| Townsville Division of GP Ltd** | Townsville | QLD |
| Canning Division of GP Ltd | Perth | WA |

(b) All Service Development Grant Projects funded in 2001 are operational. All other projects funded in 2001 through Seeding and Infrastructure Grants have been completed.

(c) AHPMC Development Grants program is one component of the after hours budget initiative. $11.7 million was allocated to this component and has been fully committed over three funding rounds.

(d) The AHPMC Program is well underway. The Commonwealth is closely monitoring the Program with the assistance of an external reference group, the Evaluation and Policy Advisory Group. The development of the Program to date has been underpinned by a strongly collaborative approach. In many instances, State and Territory Governments have worked with local project sponsors in developing their projects. State and Territory based workshops have been held throughout February 2003 to provide all stakeholders with an opportunity to identify and develop models of after hours primary medical care that are relevant and sustainable for their community.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-107

OUTCOME 4: QUALITY HEALTH CARE

Topic: ACCREDITATION

Hansard Page: CA124

Senator McLucas asked:

Provide data on the number of Aboriginal Medical Services that are accredited.

Answer:

There are 130 Aboriginal Medical Services, of which 109 are Aboriginal Community Controlled Health Services, the others are smaller or more specific services, such as a dentist.

The Department does not have data on the number of general practices, (including Aboriginal Medical Services), that are accredited. Information is available on the accreditation status of practices participating in the Practice Incentives Program (PIP) as it is a requirement for participation.

As at November 2002 there were 26 Aboriginal Medical Services participating in the PIP of which 18 were fully accredited and 8 registered for accreditation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-077

OUTCOME: 4 QUALITY HEALTH CARE

Topic: CRS AUSTRALIA CLIENT SURVEY

Hansard Page: CA 156

Senator Forshaw asked:

Could you provide the committee with a copy of the form that you ask the clients to fill in?

Answer:

A copy of CRS Australia's Client Feedback Form is attached.

CRS Australia

## What do you think of our services?

CRS Australia is always looking for ways to improve its service. An important part of doing this is asking you for feedback. Please complete the following questions and return the form to us in the pre-paid envelope.

Yours faithfully

**Regional Manager**

Client Name (Optional): _____

Rehabilitation Consultant's Name: _____

Date: _____

What type of service did you receive?: Please circle the option below

| Rehabilitation Program Government funded | Rehabilitation Program Insurer/Employer sponsored | Other Services/ Assessments |
|---|---|---|

---

Please circle the word which best describes your opinion.

1. Considering the recent services you received from CRS Australia, how satisfied were you?

| Very Dissatisfied | Dissatisfied | Neither Satisfied nor Dissatisfied | Satisfied | Very Satisfied |
|---|---|---|---|---|

2. How would you rate CRS Australia staff's ability to listen to what you had to say?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

3. How would you rate the helpfulness of CRS Australia staff?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

4. How would you rate the staff's ability to involve you in the planning of your service?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

5. How would you rate staff's ability to advise you of the purpose of the assessments provided?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

6. How would you rate staff's ability to take into account your abilities?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

7. How would you rate the level to which CRS helped you to achieve what you wanted?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

8. When phoning CRS Australia or attending the reception area how have you found the service of CRS Australia's administrative support team?

| Very Poor | Poor | Neither Good nor Poor | Good | Very Good |
|---|---|---|---|---|

9a. What were your expectations of the program/service?

_____

_____

_____

_____

9b. Were these expectations met? ☐ Yes ☐ No

10. What are the things you like about our service?

_____

_____

_____

_____

11. Can you suggest some ways in which CRS Australia could improve its service?

_____

_____

_____

_____

12. Would you recommend CRS Australia to other people? ☐ Yes ☐ No

13. Any other comments.

_____

_____

_____

_____

14. Would you be happy for us to contact you regarding your comments on the questionnaire? ☐ Yes ☐ No

**Thank you for your assistance**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-078

OUTCOME: 4 QUALITY HEALTH

Topic: CRS AUSTRALIA 2002 – 2003 BUSINESS PLAN

Hansard Page: CA 157

Senator Forshaw asked:

Can you provide us with copies of what is not on the web site?

Answer:

A copy of CRS Australia's business priorities and key performance indicators for 2002 – 2003 is attached.

## *KEY RESULT AREAS FROM THE CRS AUSTRALIA CORPORATE PLAN 2000 - 2003*

### KRA 1. CLIENTS, CUSTOMERS AND STAKEHOLDERS

*To be an externally focused organisation that reflects the needs of our clients, customers and stakeholders.*

**Outcomes:**

- provision of expert vocational assessment services and rehabilitation programs which meet both Government requirements and individual client needs
- increase in CRS Australia's contribution to the Government's social policy outcomes for the Australian community
- increase in our contribution to the value for money and service capacity available to the Australian community.

### KRA 2. BUSINESS OPERATIONS

*To be a highly productive, responsive, flexible and financially viable organisation.*

**Outcomes:**

- responsible financial management and governance
- efficient and responsive business processes which meet the diverse and changing needs of customers and stakeholders
- effective and innovative service delivery strategies which meet individual client needs
- corporate and other support services which enable autonomy and efficient effective and devolved decision-making in service delivery

### KRA 3. PEOPLE

*To provide an environment which develops, supports, empowers and rewards staff to commit to the purpose of our organisation.*

**Outcomes:**

A workplace where:

- there are high rates of staff satisfaction and retention
- we demonstrate behaviours that reflect CRS and APS values
- we recognise collaboration and teamwork are integral to achieving our results
- we have the skills, confidence and individual authority to maximise our contribution to the success of the organisation

### KRA 4. KNOWLEDGE

*To improve capability, skills and performance by enhancing organisational learning, innovation and sharing.*

**Outcomes:**

- an organisation which understands and values knowledge sharing and knowledge reuse
- an organisation where every one of us has the necessary knowledge, ready access to relevant information, and expert support to enable us, and therefore CRS, to perform at the highest possible level
- improved levels of innovation and continuous improvement
- improved performance in implementing and adapting to change

## *KEY PERFORMANCE INDICATORS*

- SLA performance targets delivered as agreed
- overall customer satisfaction is >85%
- overall client satisfaction is >85%
- financial budget achieved
- overall staff satisfaction is >85%
- staff turnover is <15%
- learning & development commitment is >3%
- quality standards achieved

## CRS AUSTRALIA BUSINESS PRIORITIES FOR 2002 - 2003

| KEY THEME | PLANNED ORGANISATIONAL OUTPUT | KRA | KEY THEME | PLANNED ORGANISATIONAL OUTPUT | KRA |
|---|---|---|---|---|---|
| **Performance** | • clear alignment of accountabilities and devolved decision-making | 1, 2 | **Workforce** | • clear identification and understanding of workforce requirements | 3, 4 |
| | • all SLA requirements met | 1 | | • alignment of recruitment, L&D and people management strategies with workforce requirements | 2,3, 4 |
| | • realistic business plans supported by justified and appropriate resourcing | 1, 2 | | • effective response to employee opinion survey results | 3 |
| | • more accessible performance reporting systems | 1,2, 4 | | | |
| **Alignment with Government** | • effective CRS contribution to the development of the Government's welfare reform initiatives | 1, 4 | **Work Processes** | • clear business priorities | 1, 2 |
| | • alignment of service delivery strategies and resourcing with target SLA populations | 1 | | • improved national business processes and work practices | 2 |
| | • improved focus on service standards and client satisfaction | 1, 4 | | • alignment of support systems with new business processes and work practices | 2, 4 |
| | • highly constructive relationships and working arrangements with FaCS, Centrelink and other key players | 1, 4 | | • revised QAIP and complaint handling processes following post implementation reviews | 2, 4 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-079

OUTCOME: 4 QUALITY HEATH CARE

Topic: ANNUAL REPORT – FUNDING

Hansard Page: CA 158

Senator Forshaw asked:

(a) Would you provide on notice a table of the amounts of funding for each year from 1995–96 through to the present in terms of Commonwealth government funding and the non – government funding that has come from your sources?

(b) In 2001 – 02 CRS Australia helped over 30,000 Australians with disabilities and injuries to access or re-enter the workforce. I have figures going back over a number of years, but would you provide the actual figures for each year?

Answer**:**

(a) CRS Australia sources of revenue $'000

| **Revenue** | **1995 – 96** | **1996 – 97** | **1997 – 98** | **1998 – 99** | **1999 – 00** | **2000 – 01** | **2001 – 02** |
|---|---|---|---|---|---|---|---|
| **Commonwealth Rehabilitation Program Funds** | $127,282 | $118,036 | $109,300 | $100,456 | $102,375 | $102,787 | $104,037 |
| **Other #** | $29,328 | $32,335 | $34,157 | $37,347 | $34,578 | $38,031 | $39143 |

# Other sources include sales of goods and services, interest, sale of assets and revenue from some government sources for work done under Section 25 of the *Disability Services Act 1986.*

(b) Total number of FaCS clients assisted by CRS Australia

| | **1995 – 96** | **1996 – 97** | **1997 – 98** | **1998 – 99** | **1999 – 00** | **2000 – 01** | **2001 - 02** |
|---|---|---|---|---|---|---|---|
| **Total** | 29919 | 30592 | 27922 | 26432 | 29222 | 31512 | 30205 |

Assisted clients are those clients on FaCS program at the start of the financial year plus new FaCS clients during the reporting period (financial year).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-080

OUTCOME: 4 QUALITY HEALTH CARE

Topic: CLIENT OUTCOMES – PLACEMENT OF 13 WEEK OR MORE IN EMPLOYMENT

Hansard Page: CA 158

Senator Forshaw asked:

Would you provide those figures for the relevant years, from 1995–96 through to the current year?

Answer:

**CRS Australia outcomes for S22 clients**

| **Outcome Types** | **1995 - 96** | **1996 – 97** | **1997 – 98** | **1998 – 99** | **1999 – 00** | **2000 – 01** | **2001 - 02** |
|---|---|---|---|---|---|---|---|
| Employment | 7385 | 5958 | 7691 | 6734 | 6108 | 6730 | 6103 |
| Secondary # | | | | | | | 1408 |
| Non Employment ## | 6812 | 7322 | 6167 | 3240 | 2452 | 3747 | 3555 |
| Incomplete | 6570 | 6810 | 6484 | 7027 | 7204 | 7587 | 5964 |
| Total | 20767 | 20090 | 20342 | 17001 | 15764 | 18064 | 17030 |

# 2001-02 A new category of Secondary outcomes is introduced, formerly part of the Non Employment outcomes

## Non Employment outcomes include Independent Living outcomes

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-081

OUTCOME: 4 QUALITY HEALTH CARE

Topic: NUMBER OF CENTRELINK CLIENTS AND OTHER CLIENTS

Hansard Page: CA 160

Senator Forshaw asked:

(a) Can you provide us with the number of clients – that is, Centrelink based clients et cetera – in the various categories that you serviced over the same period of years?
(b) I'm interested in getting a breakdown of figures that shows how many clients, on a year by year basis, come from each of those categories. I am not necessarily sure whether they are available, but perhaps you can pull them together.
(c) I have some figures but the reason I am asking you is that I do not have complete sets. I am not necessarily sure whether they are available, but perhaps you can pull them together.

Answer:

(a-c)

**Total FaCS clients assisted by CRS Australia by income source**

| | **1995/96** | **1996/97** | **1997/98** | **1998/99** | **1999/00** | **2000/01** | **2001/02** |
|---|---|---|---|---|---|---|---|
| DSP | 8501 | 8868 | 8173 | 7352 | 8357 | 9326 | 8673 |
| Newstart | 2559 | 6307 | 10870 | 11699 | 12911 | 14185 | 14385 |
| Other | 18859 | 15417 | 8879 | 7381 | 7954 | 8001 | 7147 |
| **Total** | 29919 | 30592 | 27922 | 26432 | 29222 | 31512 | 30205 |

Assisted clients are those FaCS clients on program at the start of the financial year plus new FaCS clients during the reporting period (financial year).
Other includes clients receiving payments and/or allowances such as Youth Allowance etc. It also includes FaCS clients not in receipt of income support.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-082

OUTCOME: 4 QUALITY HEALTH CARE

Topic: TOTAL STAFFING FIGURES FROM 1996-2003

Hansard Page: CA 160

Senator Forshaw asked:

I want to come to the use of the surplus for the trial, but can I first ask you to provide – you might need to take this on notice – total staffing figures from 1996 to 2003? Could you also give us a breakdown by profession, as well as, by state – is that possible?

Answer:

As attached, please note the figures provided are actual staff numbers.

**CRS Australia Staff Numbers as at 30 June 1996[1]**

| Division | Admin/ Management[2] | PO General[3] | PO Occ Therapy | PO Physiotherapy | PO Rehab Counsel. | PO Social Work | PO Speech Path. | SOP[4] | SES | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|
| **NSW/ACT** | 335 | 58 | 161 | 42 | 168 | 19 | 18 | 20 | 1 | **822** |
| **VIC/TAS** | 171 | 267 | | | | 1 | | 17 | | **456** |
| **QLD** | 111 | 171 | 3 | | | | | 10 | | **295** |
| **SA/NT** | 110 | 145 | | | | | | 8 | | **263** |
| **WA** | 71 | 82 | | | | | | 4 | | **157** |
| **Totals** | **798** | **723** | **164** | **42** | **168** | **20** | **18** | **59** | **1** | **1993** |

**CRS Australia Staff Numbers as at 30 June 1997**

| Division | Admin/ Management | PO General | PO Occ Therapy | PO Physiotherapy | PO Rehab Counsel. | PO Social Work | PO Speech Path. | SOP | SES | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|
| **NSW/ACT** | 292 | 19 | 150 | 44 | 171 | 19 | 15 | 20 | 1 | **731** |
| **VIC/TAS** | 146 | 230 | | | 1 | 1 | | 16 | | **394** |
| **QLD** | 93 | 139 | 2 | | 1 | | | 7 | | **242** |
| **SA/NT** | 70 | 115 | | | | | | 6 | | **191** |
| **WA** | 51 | 76 | | | | | | 8 | | **135** |
| **Totals** | **652** | **579** | **152** | **44** | **173** | **20** | **15** | **57** | **1** | **1693** |

**[1] Historical staff data from 1996 – 1998 has been sourced from the Department of Health and could only be determined by Division, separate ACT, Tasmanian and Northern Territory data is not available**

[2] Admin/Management comprises Administrative Services Officers Grades 1 - 6, Professional Officers Grades 1 and 2 and Senior Officers Grades A to C

[3] PO - Professional Officers Grades 1and 2

[4] Senior Officer professional Grades A to C

**CRS Australia Staff Numbers as at 30 June 1998**

| Division | Admin/ Management | PO General | PO Occ Therapy | PO Physiotherapy | PO Rehab Counsel. | PO Social Work | PO Speech Path. | SOP | SES | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|
| **NSW/ACT** | 274 | 402 | *Data* | *not* | *available* | *for* | *these* | 16 | 2 | **694** |
| **VIC/TAS** | 123 | 215 | *categories*[5] | | | | | 14 | | **351** |
| **QLD** | 94 | 156 | | | | | | 4 | | **254** |
| **SA/NT** | 59 | 107 | | | | | | 3 | | **169** |
| **WA** | 55 | 79 | | | | | | 1 | | **135** |
| **Totals** | **605** | **959** | | | | | | **38** | **2** | **1604** |

[5] Staff at PO levels under the professional categories were combined within the general category during 1997 - 98

**CRS Australia Staff Numbers as at 30 June 1999**

| State | Admin/ Management[6] | RC Occ Therapy | RC Other | RC Physiotherapy | RC Psychology | RC Rehab Counsel. | RC Social Work | RC Speech Path. | SES | ESC's[7] | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACT** | 59 | 3 | 2 | 2 | 2 | 7 | 0 | 0 | 2 | 2 | 79 |
| **NSW** | 171 | 159 | 13 | 34 | 9 | 167 | 17 | 11 | 0 | 25 | 606 |
| **VIC** | 92 | 58 | 70 | 19 | 26 | 22 | 19 | 7 | 0 | 26 | 339 |
| **QLD** | 103 | 43 | 8 | 10 | 29 | 44 | 17 | 10 | 0 | 11 | 275 |
| **SA** | 47 | 9 | 5 | 0 | 0 | 71 | 2 | 1 | 0 | 2 | 137 |
| **WA** | 47 | 31 | 12 | 4 | 27 | 10 | 9 | 0 | 0 | 6 | 146 |
| **TAS** | 15 | 6 | 19 | 0 | 0 | 12 | 0 | 1 | 0 | 3 | 56 |
| **NT** | 6 | 7 | 2 | 0 | 6 | 3 | 1 | 0 | 0 | 3 | 28 |
| **TOTALS** | **540** | **316** | **131** | **69** | **99** | **336** | **65** | **30** | **2** | **78** | **1666** |

**CRS Australia Staff Numbers as at 30 June 2000**

| State | Admin/ Management | RC Occ Therapy | RC Other | RC Physiotherapy | RC Psychology | RC Rehab Counsel. | RC Social Work | RC Speech Path. | SES | ESC's | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACT** | 62 | 5 | 0 | 2 | 1 | 6 | 0 | 1 | 2 | 2 | 81 |
| **NSW** | 168 | 178 | 10 | 29 | 9 | 178 | 13 | 11 | 0 | 29 | 625 |
| **VIC** | 108 | 70 | 56 | 23 | 41 | 31 | 26 | 10 | 0 | 34 | 399 |
| **QLD** | 98 | 43 | 7 | 15 | 27 | 47 | 21 | 8 | 0 | 15 | 281 |

[6] Admin/Management includes National/Divisional and Regional Managers
[7] ESC's - Employment Services Consultant

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **SA** | 47 | 10 | 5 | 0 | 1 | 72 | 4 | 0 | 0 | 3 | 142 |
| **WA** | 45 | 35 | 6 | 2 | 29 | 13 | 10 | 0 | 0 | 8 | 148 |
| **TAS** | 16 | 6 | 17 | 0 | 1 | 13 | 2 | 0 | 0 | 5 | 60 |
| **NT** | 8 | 6 | 0 | 0 | 6 | 6 | 1 | 0 | 0 | 3 | 30 |
| **TOTALS** | **552** | **353** | **101** | **71** | **115** | **366** | **77** | **30** | **2** | **99** | **1766** |

**CRS Australia Staff Numbers as at 30 June 2001**

| State | Admin/ Management | RCOcc Therapy | RC Other | RC Physiotherapy | RC Psychology | RC Rehab Counsel. | RC Social Work | RC Speech Path. | SES | ESC's | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACT** | 37 | 5 | 0 | 2 | 1 | 5 | 0 | 1 | 2 | 3 | 56 |
| **NSW** | 177 | 142 | 18 | 31 | 18 | 173 | 8 | 11 | 0 | 38 | 616 |
| **VIC** | 118 | 74 | 50 | 25 | 41 | 39 | 25 | 9 | 0 | 32 | 413 |
| **QLD** | 93 | 44 | 4 | 14 | 27 | 49 | 17 | 5 | 0 | 9 | 262 |
| **SA** | 44 | 14 | 4 | 1 | 1 | 74 | 7 | 0 | 0 | 4 | 149 |
| **WA** | 42 | 29 | 4 | 3 | 29 | 15 | 11 | 0 | 0 | 9 | 142 |
| **TAS** | 18 | 8 | 13 | 0 | 2 | 12 | 2 | 0 | 0 | 5 | 60 |
| **NT** | 9 | 7 | 0 | 0 | 5 | 6 | 2 | 0 | 0 | 3 | 32 |
| **TOTALS** | **538** | **323** | **93** | **76** | **124** | **373** | **72** | **26** | **2** | **103** | **1730** |

**CRS Australia Staff Numbers as at 30 June 2002**

| State | Admin/ Management | RC Occ Therapy | RC Other | RC Physiotherapy | RC Psychology | RC Rehab Counsel. | RC Social Work | RC Speech Path. | SES | ESC's | TOTALS |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **ACT** | 41 | 4 | 0 | 2 | 1 | 6 | 0 | 2 | 3 | 3 | 62 |
| **NSW** | 167 | 137 | 28 | 32 | 29 | 150 | 21 | 12 | 0 | 42 | 618 |
| **VIC** | 125 | 61 | 48 | 24 | 47 | 32 | 25 | 10 | 0 | 33 | 405 |
| **QLD** | 100 | 45 | 4 | 12 | 33 | 50 | 16 | 4 | 0 | 12 | 276 |
| **SA** | 48 | 13 | 6 | 1 | 2 | 71 | 6 | 0 | 0 | 4 | 151 |

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **WA** | 37 | 30 | 5 | 3 | 29 | 13 | 12 | 0 | 0 | 6 | 135 |
| **TAS** | 15 | 11 | 11 | 0 | 2 | 10 | 2 | 0 | 0 | 4 | 55 |
| **NT** | 7 | 9 | 0 | 0 | 2 | 4 | 1 | 1 | 0 | 3 | 27 |
| **TOTALS** | **540** | **310** | **102** | **74** | **145** | **336** | **83** | **29** | **3** | **107** | **1729** |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-083

OUTCOME: 4 QUALITY HEALTH CARE

Topic: CRITERIA USED TO DETERMINE EFFECTIVE PERFORMANCE

Hansard Page: CA 160

Senator Forshaw asked:

Is there a difference between how fee for service workers are assessed compared to other workers?

Answer:

No. All employees are assessed on their performance with clients, their demonstration of CRS Australia's values and their contribution to the broader organisation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-084

OUTCOME: 4 QUALITY HEALTH CARE

Topic: FACS ANNUAL REPORT – SIGNIFICANT DIVIDEND PAYMENTS TO FUND FACS ASSESSMENT AND CONTESTABILITY TRIALS

Hansard Page: CA 162-163

Senator Forshaw asked:

(a) Can you give us some figures? How much would you use to fund the FaCS assessment and contestability trials?
(b) If the dividend payments did not have to be made, what would the surplus have been?

Answer:

(a) A $10 million dividend was provided to Government over the financial years 1999-2000 and 2000-01. FaCS has provided costs for the Assessment and Contestability Trial in their answers to Questions on Notice to this Senate Committee.

(b) The net operating surplus of $9.974 million was unaffected by the dividend payments. Dividend payments are charged directly against equity in the balance sheet, are not reported as an expense and so do not affect the operating result for an entity.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question E03-085

OUTCOME: 4 QUALITY HEALTH CARE

Topic: FACS ANNUAL REPORT – CONTINUING SALE OF PROPERTIES

Hansard Page: CA 164-165

Senator Forshaw asked:

(a) Can you provide us with a list of the properties that have been sold since 1996 and the price at which they were sold?
(b) Can you tell me how many of the properties that have been sold have been leased back and what the cost is?
(c) What has happened to the revenue from property sales?

Answer:

(a-b) See Table below.

**Properties sold by CRS Australia since 01 January 1996**

| Property | Revenue Received | Financial Year | Lease Back Y/N | Current Annual Lease Cost |
|---|---|---|---|---|
| **Victoria** | | | | |
| 206 Doveton St Ballarat | $325,000 | 2001 – 02 | Y | $35,000 |
| 103 Bridge St Bendigo | $158,000 | 1996 – 97 | N | |
| 279 Gray St Hamilton | $146,000 | 1997 – 98 | Y | Property no longer occupied by CRS Australia |
| Unit 4 1-3 Langtree Parade Mildura | $92,000 | 1997 – 98 | N | |
| 8 Sinclair Avenue Morwell | $77,000 | 1998 – 99 | N | |
| 68 Maude St Shepparton | $203,000 | 1998 – 99 | N | |

| | | | | |
|---|---|---|---|---|
| 16A Darlot St Horsham | $125,000 | 1998 – 99 | N | |
| 5 Rutherford St Swan Hill | $137,000 | 2001 – 02 | Y | $12,000 |
| 9 Hunter St Wonthaggi | $90,000 | 2000 – 01 | N | |
| **NSW** | | | | |
| 7 Lagoon St Goulburn | $160,000 | 2001 – 02 | Y | $15,400 |
| Shops 1&2, Sands St Tweed Heads | $210,000 | 2002 – 03 | N | |
| 96 Winsor Road Richmond | $331,000 | 2001 – 02 | Y | $25,000 |
| 76 Broughton St Camden | $180,000 | 1998 – 99 | N | |
| 56 Hume Highway Mittagong | $252,000 | 2001 – 02 | Y | $14,000 |
| 1 Carrington Avenue Katoomba | $380,000 | 2001 – 02 | N | |
| **QLD** | | | | |
| 32 Horseshoe Bend Road Gympie | $95,000 | 1997 – 98 | Y | $12,480 |
| Unit 1, 211 Beatrice St Townsville | $168,000 | 2000 – 01 | N | |
| 37 Wood St Warwick | $85,000 | 2000 – 01 | Y | Property no longer occupied by CRS Australia |
| 4 Scheu St Innisfail | $95,000 | 1997 – 98 | N | |
| **SA** | | | | |
| 11 Second St Murray Bridge | $110,000 | 1998 – 1999 | Y | $13,200 |
| 11 Carlton St Gawler | $190,000 | 1998 – 99 | Y | $22,500 |
| 181 Giles St Unit3/4 Adelaide | $380,000 | 1997 – 98 | N | |
| 21 Merghiny Drive Ceduna | $87,000 | 2000 – 01 | N | |

| | | | | |
|---|---|---|---|---|
| **WA** | | | | |
| 10 Duke St Albany | $270,000 | 1997 – 98 | Y | $23,500 |
| 44 De Marchi Road Broome | $237,500 | 2001 – 02 | N | |
| Unit 4, 8 Eric St Geralton | $86,000 | 2001 – 02 | N | |
| 21 Nankiville St Kalgoorlie | $125,000 | 2001 – 02 | N | |
| 1/5 President St Kalgoorlie | $62,000 | 2001 – 02 | N | |
| 4/5 President St Kalgoorlie | $68,000 | 2001 – 02 | N | |
| 2 Gillams Place Karratha | $252,000 | 2000 - 01 | N | |
| 3 Cassia Court Katherine | $125,000 | 2001 – 02 | N | |
| Lot 1048 Wollybutt Place Kununurra | $110,000 | 2001 – 02 | N | |

(c) Net gains from property sales are recorded as revenue from ordinary activities as detailed in CRS Australia's financial statements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-176

OUTCOME 4: QUALITY HEALTH CARE

Topic: COORDINATED CARE TRIALS

Written Question on Notice

Senator McLucas asked:

(a) What is the current status of the coordinated care trials? Which of the first round trials were extended and what have been the results from the latest trials?
(b) What are the factors that have caused the costs of these trials to increase? Why have the anticipated savings on the delivery of service not been realised?
(c) Has the experience with the aboriginal community health coordinated care been better? If so what are the factors that cause a difference?

Answer:

(a) There are currently five second round coordinated care trials. Tripartite Deeds of Agreement were signed between the Commonwealth, the relevant State/Territory and the Trial Sponsor, for four trials in June 2002. The fifth was signed in October 2002. Trials are currently finalising their set-up arrangements before they commence delivering services and testing their models of care.

Three of the second round trials are building on their experience from participation in the first round of trials: Coordinated HealthCare, Victoria; South West Aboriginal Medical Service Coordinated Care Trial 2, Western Australia; and TEAMCare Health II, Queensland.

As the trials are at an early stage, no results are yet available.

(b) Given the early stage of the second round, it is not yet possible to report on any results of the trials or on financial implications.

(c) The second round trials targeting Aboriginal people are still finalising their set-up arrangements before they commence delivering services and testing their models of care. Therefore, it is not yet possible to report of their results.

Results of the evaluation of the first round of trials for Aboriginal peoples indicate that significant progress was made in improving access to services, health care planning and population health programs that address priority needs at the community level.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-071

OUTCOME 4: QUALITY HEALTH CARE

Topic: DIVISIONS OF GENERAL PRACTICE

Written Question on Notice

Senator Allison asked:

What was the amount paid by the Department of Health and Ageing (and what was this as a proportion of the organisations' total operating costs) in 2001-02 to:
(a) Australian Divisions of General Practice?
(b) State Based Organisations (of General Practice)?
(c) Individual Divisions of General Practice?

Answer:

| | Division/SBO | Total DoHA Funding | Total Division Income | DoHA funding as a % of total income |
|---|---|---|---|---|
| **a) Australian Divisions of General Practice** | | | | |
| | Australian Divisions of General Practice | **$5,414,833** | **$7,016,531** | **77%** |
| **b) State Based Organisations (of General Practice)** | | | | |
| 261 | Alliance of NSW Divisions | **$2,381,214** | $3,941,225 | **60%** |
| 361 | General Practice Divisions Victoria | **$1,189,343** | $2,079,062 | **57%** |
| 461 | Queensland Division of General Practice | **$2,336,361** | $2,736,414 | **85%** |
| 561 | South Australian Divisions Inc. | **$721,496** | $1,556,336 | **46%** |
| 661 | General Practice Divisions Western Australia | **$1,118,946** | $3,563,726 | **31%** |
| 761 | Tasmanian General Practice Divisions (inc Rural Workforce Agency) | **$1,732,960** | $2,466,680 | **70%** |
| 861 | General Practice Divisions Northern Territory | **$647,458** | $843,391 | **77%** |
| 961 | ACT State Based Organisation/ACT Division | **$1,169,869** | $2,264,139 | **52%** |
| | **SBO TOTAL:** | **$11,297,647** | **$19,450,972** | **58%** |
| **c) Individual Divisions of General Practice** | | | | |
| **New South Wales** | | | | |
| 201 | Central Sydney Division of General Practice | **$1,230,165** | $1,369,720 | **90%** |
| 202 | Eastern Sydney Division of General Practice Ltd | **$753,294** | $864,128 | **87%** |
| 203 | South Eastern Sydney Division of General Practice | **$691,757** | $842,337 | **82%** |
| 204 | Genprac Ltd (Canterbury) | **$603,643** | $734,496 | **82%** |
| 205 | Bankstown G.P. Division Health Service Inc | **$621,375** | $698,250 | **89%** |
| 206 | The Western Sydney Division of General Practice Inc | **$1,912,872** | $2,339,474 | **82%** |
| 208 | The Northern Sydney Division of General Practice Inc | **$772,125** | $854,227 | **90%** |
| 209 | St George District Division of General Practice Inc | **$1,010,068** | $1,030,102 | **98%** |
| 210 | Liverpool Division of General Practice Ltd | **$562,268** | $694,291 | **81%** |
| 211 | Division of General Practice , Fairfield Health Service Inc. | **$939,694** | $1,021,658 | **92%** |
| 212 | Hornsby Ku-Ring-Gai Division of General Practice Ltd | **$1,267,214** | $1,735,508 | **73%** |
| 213 | Manly Warringah Division of General Practice Ltd | **$757,943** | $814,356 | **93%** |

| | | | | |
|---|---|---|---|---|
| 214 | Sutherland Division of General Practice Inc | **$720,738** | $832,662 | **87%** |
| 215 | Macarthur Division of General Practice Ltd | **$911,623** | $963,028 | **95%** |
| 216 | Illawarra Division of General Practice Ltd | **$1,112,054** | $1,539,380 | **72%** |
| 217 | Hunter Urban Division of General Practice Ltd | **$2,877,565** | $4,961,248 | **58%** |
| 218 | Hunter Rural Division of General Practice Ltd | **$1,296,905** | $1,620,623 | **80%** |
| 219 | Central Coast Division of General Practice Inc | **$1,297,331** | $1,484,941 | **87%** |
| 220 | The Shoalhaven Division of General Practice Inc | **$702,603** | $764,137 | **92%** |
| 221 | The South East NSW Division of General Practice Ltd | **$1,456,690** | $1,945,863 | **75%** |
| 223 | Hastings Macleay Division of General Practice Ltd | **$773,289** | $1,128,870 | **69%** |
| 224 | Mid North Coast (NSW) Division of General Practice Ltd | **$1,166,007** | $1,923,421 | **61%** |
| 225 | Northern Rivers Divisions of General Practice (NSW) Ltd | **$1,694,133** | $2,193,470 | **77%** |
| 226 | Tweed Valley Division of General Practice | **$637,300** | $676,047 | **94%** |
| 227 | The New England Division of General Practice Ltd | **$788,618** | $936,382 | **84%** |
| 228 | Riverina Division of General Practice Inc | **$1,250,984** | $1,290,084 | **97%** |
| 229 | NSW Central West Division of General Practice Ltd | **$1,303,012** | $1,571,652 | **83%** |
| 230 | Dubbo/Plains Division of General Practice Ltd | **$880,992** | $1,143,189 | **77%** |
| 231 | Barwon Division of General Practice Inc | **$679,261** | $819,702 | **83%** |
| 232 | Murrumbidgee Division of General Practice Ltd | **$789,805** | $833,344 | **95%** |
| 233 | NSW Outback Division of General Practice Ltd | **$642,626** | $713,956 | **90%** |
| 235 | Southern Highlands Division of General Practice Inc | **$621,436** | $656,870 | **95%** |
| 236 | North West Slopes (NSW) Division of General Practice Ltd | **$569,944** | $603,401 | **94%** |
| 237 | The Nepean Division of General Practice Inc | **$678,236** | $716,433 | **95%** |
| 238 | Blue Mountains Division of General Practice Inc | **$348,858** | $393,750 | **89%** |
| 240 | Hawkesbury Division of General Practice Ltd | **$361,756** | $385,121 | **94%** |
| 241 | Barrier Division of General Practice Ltd | **$422,130** | $498,592 | **85%** |
| **Victoria** | | | | |
| 301 | Melbourne Division of General Practice | **$809,461** | $1,339,336 | **60%** |
| 302 | North-East Valley Division of General Practice | **$743,120** | $1,149,803 | **65%** |
| 303 | Inner East Melbourne Division of General Practice | **$716,047** | $748,316 | **96%** |
| 304 | South City GP Services | **$641,497** | $1,164,782 | **55%** |
| 305 | Westgate Division of Family Medicine | **$573,602** | $638,135 | **90%** |
| 306 | Western Melbourne Division of General Practice | **$873,967** | $1,065,536 | **82%** |
| 307 | North West Melbourne Division of General Practice | **$999,323** | $1,108,723 | **90%** |
| 308 | Northern Division of General Practice, Melbourne | **$946,030** | $991,841 | **95%** |
| 310 | Whitehorse Division of General Practice Inc | **$1,180,331** | $2,073,273 | **57%** |
| 311 | Greater South East Melbourne Division of General Practice | **$762,163** | $806,815 | **94%** |
| 312 | Monash Division of General Practice (Moorabbin) | **$704,947** | $764,992 | **92%** |
| 313 | Central Bayside Division of General Practice | **$663,638** | $1,196,594 | **55%** |
| 314 | Knox Division of General Practice | **$788,415** | $826,198 | **95%** |
| 315 | Dandenong Division of General Practice Inc | **$906,230** | $1,455,051 | **62%** |
| 316 | Mornington Peninsula Division of General Practice | **$939,809** | $982,300 | **96%** |
| 317 | General Practitioners Association of Geelong | **$985,390** | $2,121,871 | **46%** |
| 318 | Central Highlands Division of General Practice | **$1,023,315** | $1,305,388 | **78%** |
| 319 | North-East Victorian Division of General Practice | **$1,054,920** | $1,635,420 | **65%** |
| 320 | Lilydale and Yarra Valley Division of General Practice | **$455,531** | $566,317 | **80%** |
| 321 | Sherbrooke and Pakenham Division of General Practice | **$361,459** | $374,152 | **97%** |
| 322 | South Gippsland Division of General Practice | **$734,592** | $775,751 | **95%** |
| 323 | Central-West Gippsland Division of General Practice | **$806,057** | $1,156,213 | **70%** |
| 324 | Otway Division of General Practice | **$965,064** | $1,166,557 | **83%** |
| 325 | Ballarat & District Division of General Practice Inc | **$667,560** | $1,495,062 | **45%** |
| 326 | Bendigo & District Division of General Practice | **$724,998** | $992,813 | **73%** |
| 327 | The Goulburn Valley Division of General Practice Ltd | **$797,694** | $1,032,591 | **77%** |
| 328 | East Gippsland Division of General Practice | **$736,391** | $878,706 | **84%** |
| 329 | Border Division of General Practice | **$628,396** | $932,982 | **67%** |
| 330 | West Vic Division of General Practice Inc | **$1,487,756** | $2,331,611 | **64%** |
| 331 | Murray-Plains Division of General Practice | **$657,612** | $1,093,847 | **60%** |
| 332 | Mallee Division of General Practice | **$762,081** | $1,105,925 | **69%** |
| **Queensland** | | | | |
| 401 | Brisbane Inner South Division | **$557,245** | $929,101 | **60%** |
| 402 | Brisbane South Division | **$943,865** | $1,070,594 | **88%** |
| 403 | Bayside Division (Brisbane) | **$741,448** | $875,347 | **85%** |
| 404 | Logan Area Division | **$1,042,173** | $1,136,784 | **92%** |

| | | | | |
|---|---|---|---|---|
| 405 | Brisbane North Division | **$2,113,662** | $2,384,535 | **89%** |
| 406 | Gold Coast Division | **$1,239,809** | $1,416,803 | **88%** |
| 407 | Redcliffe Bribie Caboolture Division | **$669,739** | $713,088 | **94%** |
| 408 | Ipswich and West Moreton Division | **$1,002,694** | $1,373,692 | **73%** |
| 409 | Toowoomba and District Division | **$1,060,790** | $1,206,484 | **88%** |
| 410 | Central Queensland Rural Division | **$891,001** | $1,119,568 | **80%** |
| 411 | Mackay Division | **$921,282** | $1,035,597 | **89%** |
| 412 | Townsville Division | **$1,135,018** | $1,386,082 | **82%** |
| 413 | Cairns Division | **$715,103** | $1,045,946 | **68%** |
| 414 | Southern Queensland Rural Division | **$2,724,146** | $2,942,246 | **93%** |
| 415 | Central West Rural Division | **$525,244** | $1,034,899 | **51%** |
| 416 | Northern & Western Queensland Primary Health Care | **$2,411,792** | $3,425,296 | **70%** |
| 417 | Far North Queensland Rural Division | **$1,212,801** | $1,741,249 | **70%** |
| 418 | Sunshine Coast Division | **$1,691,791** | $1,796,620 | **94%** |
| 419 | Capricornia Division | **$787,963** | $1,108,183 | **71%** |
| 420 | Wide Bay Division | **$757,392** | $1,095,037 | **69%** |
| **South Australia** | | | | |
| 501 | Adelaide Western Division | **$1,070,695** | $1,615,758 | **66%** |
| 502 | Adelaide Northern Division | **$908,930** | $1,094,041 | **83%** |
| 503 | Adelaide North East Division | **$721,418** | $818,269 | **88%** |
| 504 | Adelaide Central & Eastern Division | **$736,498** | $1,501,678 | **49%** |
| 505 | Southern Division | **$1,375,249** | $2,072,915 | **66%** |
| 506 | Barossa Division | **$488,293** | $574,681 | **85%** |
| 507 | Yorke Peninsula Division | **$480,369** | $591,216 | **81%** |
| 508 | Mid North Division | **$573,498** | $833,297 | **69%** |
| 509 | Riverland Division | **$527,829** | $555,539 | **95%** |
| 510 | Limestone Coast Division | **$643,483** | $776,274 | **83%** |
| 511 | Eyre Peninsula Division | **$594,909** | $849,115 | **70%** |
| 512 | Flinders & Far North Division | **$481,964** | $858,409 | **56%** |
| 513 | Murray Mallee Division | **$466,486** | $545,041 | **86%** |
| 514 | Adelaide Hills Division | **$587,285** | $698,710 | **84%** |
| **Western Australia** | | | | |
| 601 | Perth and Hills Division | **$951,233** | $1,325,206 | **72%** |
| 602 | Perth Central Coastal Division | **$470,844** | $835,380 | **56%** |
| 603 | Osborne Division | **$1,181,080** | $1,889,857 | **62%** |
| 604 | Canning Division | **$1,646,887** | $2,102,241 | **78%** |
| 605 | Fremantle Division | **$877,350** | $1,308,155 | **67%** |
| 606 | Rockingham Division | **$441,072** | $576,543 | **77%** |
| 607 | Peel South West Division | **$1,042,886** | $1,063,933 | **98%** |
| 609 | Great Southern Division | **$847,678** | $1,221,669 | **69%** |
| 610 | Kimberley Division | **$697,950** | $748,770 | **93%** |
| 611 | Eastern Goldfields Division | **$816,865** | $982,878 | **83%** |
| 612 | Midwest Division | **$724,331** | $796,748 | **91%** |
| 613 | Greater Bunbury Division | **$592,563** | $997,359 | **59%** |
| 614 | Pilbara Division | **$675,422** | $908,680 | **74%** |
| 615 | Wheatbelt Division | **$1,124,576** | $1,434,276 | **78%** |
| **Tasmania** | | | | |
| 701 | Southern Division | **$916,147** | $1,108,876 | **83%** |
| 702 | GP North Division | **$947,185** | $1,281,038 | **74%** |
| 703 | North-West Division | **$943,519** | $1,137,561 | **83%** |
| **Northern Territory** | | | | |
| 801 | Top End Division of General Practice | **$1,277,913** | $1,810,238 | **71%** |
| 802 | Central Australian Division of Primary Health Care | **$1,072,980** | $1,276,372 | **84%** |
| | **DIVISIONS TOTAL:** | **$110,254,053** | **$143,899,489** | **77%** |
| | **GRAND TOTAL:** | **$126,966,533** | **$170,366,992** | **75%** |
| **Figures GST Inclusive** | | | | |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-072

OUTCOME 4: QUALITY HEALTH CARE

Topic: DIVISIONS OF GENERAL PRACTICE

Written Question on Notice

Senator Allison asked:

(a) How many Divisions since June 2002 have participated in seminars organised through or advertised by the Divisions of General Practice where the purpose is to inform GPs about how to introduce private billing?
(b) What has been the total cost of these seminars?
(c) What organisation(s) have paid what amounts for these seminars?

Answer:

(a-c) The Department collects information about the nature of educational activities arranged by Divisions of General Practice through an Annual Survey of Divisions (ASD). The ASD for 2000-01 reports that Divisions organised or conducted a wide variety of training and educational events, the most frequent being continuing professional development activities, training for practice staff, and practice management training. A breakdown of these activities, and the number of Divisions involved, is shown at Attachment A. The Department does not collect information regarding the individual seminars arranged by Divisions. A number of these seminars are funded from non-Commonwealth sources.

| **Educational and quality assurance activities Divisions held or coordinated in 2000-01** | **Number of Divisions (% of 123)** |
|---|---|
| Continuing Professional Development – 2 points per hour | 121 (98) |
| Training for practice staff | 112 (91) |
| Practice management training for GPs and/or staff | 99 (81) |
| Mock accreditation visits | 83 (68) |
| Clinical audits | 79 (64) |
| Peer support for GPs | 64 (52) |
| Continuing Professional Development – 3 points per hour | 57 (46) |
| Training in teaching or facilitation skills for GPs | 41 (33) |
| Leadership training for GPs | 37 (30) |
| Inter-practice visits | 36 (29) |
| Clinical attachments | 36 (29) |
| Facilitation of GP participation in the RACGP training program | 34 (28) |
| Coordination of GP education of undergraduates | 21 (17) |
| Formal peer review activities, other than accreditation | 15 (12) |
| Other[#] | 17 (14) |

[#]17 Divisions reported a total of 25 other activities, including skills training (eg anaesthetic simulation, health assessment, mental health), professional development (peer education, visits for overseas trained doctors, stress management), training in various Information Technology and Quality Use of Medicines topics, and practice visits relating to immunisation and cold chain audit.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-150

OUTCOME 4: QUALITY HEALTH CARE

Topic: PRACTICE INCENTIVE PAYMENTS

Written Question on Notice

Senator McLucas asked:

(a) What evidence does the Department have that PIP has lead to improved health outcomes?
(b) What evidence does the Department have that PIP causes doctors to change (ie improve the quality of) their clinical practice?
(c) How many practices have enrolled in PIP since its inception? (could we have a breakdown by incentive program and by quarter)
(d) How many practices have dropped out of PIP since its inception? (could we have a breakdown by incentive program and by quarter)
(e) What is known about the reasons why practices dropped out?
(f) How many practices dropped out of the program following the requirement for practices to 'register for accreditation' as a criterion for access to the incentives?

Answer:

(a) This question was answered at the hearing – refer to Hansard CA 124
(b) The PIP provides incentives to GPs to implement evidence-based best practice in a range of areas, for example chronic disease management, computerization, after hours care and prescribing. We have information on the take-up of the incentives and by implication the extent of the change in general practice.

(c) The following tables show the change in practice participation in the PIP since the program's introduction in August 1999.

| Payment quarter | Aug-99 | Nov-99 | Feb-00 | May-00 | Aug-00 | Nov-00 | Feb-01 | May-01 | Aug-01 | Nov-01 | Feb-02 | May-02 | Aug-02 | Nov-02 | Feb-03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| No. of practices | 4,901 | 5,022 | 5,088 | 5,172 | 5,231 | 5,249 | 5,248 | 5,260 | 5,216 | 5,273 | 4,344 | 4,482 | 4,525 | 4,553 | 4,568 |
| Gains | 4,901 | 147 | 123 | 153 | 164 | 104 | 87 | 88 | 48 | 87 | 70 | 181 | 85 | 64 | 70 |
| Losses | 0 | 26 | 57 | 69 | 105 | 86 | 88 | 76 | 92 | 30 | 999 | 43 | 42 | 36 | 55 |
| Net change | 4,901 | 121 | 66 | 84 | 59 | 18 | -1 | 12 | -44 | 57 | -929 | 138 | 43 | 28 | 15 |

(d) See (c)
(e) This question has previously been answered – refer to QON E03000106
(f) This question has previously been answered – refer to QON E03000106

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-105

OUTCOME 4: QUALITY HEALTH CARE

Topic: PRACTICE INCENTIVES PROGRAM (PIP) – GP PARTICIPATION

Hansard Page: CA123

Senator McLucas asked:

Provide a list of organisations that allow GP participation and input into PIP, and their membership

Answer:

There are a number of organisations that allow GP participation and input into the Practice Incentives Program (PIP). GP input and participation is usually through committees with input into the overall management of the PIP or through specific working groups to aid in the design of specific incentives in the PIP. The membership for each committee or working group is listed in the Tables below.

The General Practice Financing Group (GPFG) was established in May 1998 to develop a financing agreement and to address of a number of related financing issues, including developing aspects of the Practice Incentive Program. The GPFG comprised the Australian Medical Association (AMA), Royal Australian College of General Practice (RACGP), Rural Doctors Association of Australia (RDAA), Australian Divisions of General Practice (ADGP) and the Department of Health and Ageing (DoHA).

During the period of the GP MoU, a management committee comprising the RACGP, RDAA, ADGP and the Department oversighted the development of PIP incentives, in particular the development of the Asthma, Diabetes, Cervical Screening, Mental Health and Practice Nurse incentives.

**Table 1: National Integrated Diabetes Program – NDSG Working Group (Ongoing)**

| | |
|---|---|
| General Practice Partnership Advisory Council | Australian Division of General Practice |
| University of New South Wales | General Practice Computing Group |
| Western Sydney Area Health Service | Pharmacy Guild |
| Prince of Wales Hospital | Diabetes Australia |
| Mater Health Services | Rural Doctors Association of Australia |
| Royal Australian College of General Practitioners | Department of Health and Ageing |

**Table 2: Cervical Screening Incentives Implementation Group**

| | |
|---|---|
| Rural Doctors Association of Australia | Royal Australian College of General Practitioners |
| Australian Division of General Practice | National Advisory Committee to the National Cervical Screening Program |
| National Advisory Committee to the National Cervical Screening Program | Australian Medical Association |

**Table 3: National Asthma Reference Group (Ongoing)**

| | |
|---|---|
| General Practice Partnership Advisory Council | Asthma Australia |
| National Aboriginal Community Controlled Health Organisations | National Asthma Council |
| Thoracic Society of Australian and New Zealand | Royal Australian College of General Practitioners |
| A Consumer | Pharmaceutical Society of Australia |
| Department of Health and Ageing | National Health Priority Action Council (through a nominee) |
| An Independent Chair | |

**Table 4: Better Outcomes Implementation Advisory Group (BOIAG) formerly the Committee for Incentives for Mental Health (Ongoing)**

| | |
|---|---|
| Australian Division of General Practice | Mental Health Council of Australia |
| Beyond Blue | Australian Psychological Society |
| Rural Doctors Association of Australia | Australian Medical Association |
| AHMAC National mental Health Working Group | Royal Australian and New Zealand College of Psychiatrists |
| Royal Australian College of General Practitioners - GP Mental Health Standards Collaboration | Department of Health and Ageing |

**Table 5: Joint GPPAC-GPMoU Committee on Practice Nurses, including a Technical Advisory Group (TAG)**

| | |
|---|---|
| Australian Division of General Practice | Royal Australian College of General Practitioners |
| Rural Doctors Association of Australia | Department of Health and Ageing |
| Royal College of Nursing Australia | |

Note: This joint advisory group was formed in July 2001 to develop the detail of the Practice Nurses PIP incentive. The advisory group was disbanded with the implementation of the incentive.

**Table 6: Practice Nurse Steering Group (Ongoing)**

| | |
|---|---|
| Royal Australian College of General Practitioners | Rural Doctors Association of Australia |
| Royal College of Nursing, Australia | Australian Health Ministers Advisory Council |
| Australian Nursing Federation | Health Consumers of Rural and Remote Australia |
| Australian Division of General Practice | Australian Medical Association |
| Australian Practice Nurse Association | Australian College of Rural and Remote Medicine |
| Department of Health and Ageing | |

**Table 7: GP Immunisation Incentives Scheme**

| | |
|---|---|
| Royal Australian College of General Practitioners | Rural Doctors Association of Australia |
| Australian Medical Association | Australian Division of General Practice |
| Australian Medical Centres Association | National Association of General Practitioners of Australia |
| Australian Association of General Practitioners | Australian Urban Divisions of General Practice |
| Australian Rural Divisions of General Practice | |

Note: Input to the development of the GP Immunisation Incentives Scheme came originally from the GP Forum in 1997 which had the above membership

**Table 8: GP Immunisation Incentives Advisory Group (Ongoing)**

| | |
|---|---|
| Health Insurance Commission | Australian Medical Association |
| Royal Australian College of General Practitioners | Divisions of General Practice |
| Australian Division of General Practice | State Based Organisation representative |
| Consumer Health Forum Representative | Department of Health and Ageing |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-106

OUTCOME 4: QUALITY HEALTH CARE

Topic: PRACTICE INCENTIVES PROGRAM (PIP) – DROP-OUT DATA

Hansard Page: CA 124

Senator McLucas asked:

Has any analysis been done on why practices drop out of the Practice Incentives Program (PIP)?

Answer:

Yes. The PIP is a dynamic program with practices regularly joining and leaving. This reflects changing business environments where practices relocate, close and amalgamate. Overall the trend is for increasing practice participation.

In February 2002 when accreditation became the entry requirement for PIP some 927 practices became ineligible for the program. These practices had joined the PIP prior to January 2001 and were required to become fully accredited to remain in the program. Since that time a number of these practices have rejoined after becoming fully accredited. Table 1 (attached) shows the practice of the PIP over time.

**Attachment**

Table 1. PIP practice participation since implementation.

| **Practice Participation** | Aug-99 | Nov-99 | Feb-00 | May-00 | Aug-00 | Nov-00 | Feb-01 | May-01 | Aug-01 | Nov-01 | Feb-02 | May-02 | Aug-02 | Nov-02 | Feb-03 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Number of practices in the PIP | 4,901 | 5,022 | 5,088 | 5,172 | 5,231 | 5,249 | 5,248 | 5,260 | 5,216 | 5,273 | 4,344 | 4,482 | 4,525 | 4,553 | 4,568 |
| Proportion of total patient coverage provided by PIP practices | 74% | 76% | 76% | 78% | 78% | 79% | 79% | 80% | 80% | 81% | 74% | 76% | 77% | 78% | 78% |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-177

OUTCOME 5: RURAL HEALTH

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

(a) Can the Department provide updated statistics showing the number of doctors practicing in each of the 7 classifications of urban and rural zones?
(b) Can these figures be provided on an 'effective full time doctor' basis showing the number of vocationally registered doctors, the number of trainees and the number of overseas trained doctors in these areas?

Answer:

(a-b) For updated figures on GP FTE by RRMA for the number of vocationally registered doctors and the number of trainees, see Table 1. For similar figures on the number of overseas-trained GPs, see Table 2.

Table 1: GP FTE by GP type and RRMA for Financial Year 2001-02

| | Non-Vocationally Registered GPs | Vocationally Registered GPs | GP Trainees | Total |
|---|---|---|---|---|
| Capital City | 767 | 8,474 | 254 | 9,496 |
| Other Metro | 71 | 955 | 42 | 1,068 |
| Large Rural | 80 | 733 | 44 | 858 |
| Small Rural | 104 | 733 | 84 | 921 |
| Other Rural | 237 | 1,139 | 145 | 1,520 |
| Remote Centre | 26 | 73 | 13 | 112 |
| Other Remote | 53 | 78 | 13 | 144 |
| **Australia** | **1,339** | **12,186** | **594** | **14,119** |

Note: Figures calculated prior to rounding

Table 2: GP FTE by Place of Basic Qualifications by RRMA for Financial Year 2001/02

| | Australia | Overseas | Total |
|---|---|---|---|
| Capital City | 6,834 | 2,662 | 9,496 |
| Other Metro | 769 | 299 | 1,068 |
| Large Rural | 634 | 223 | 858 |
| Small Rural | 635 | 286 | 921 |
| Other Rural | 1,064 | 456 | 1,520 |
| Remote Centre | 71 | 41 | 112 |
| Other Remote | 77 | 67 | 144 |
| Australia | 10,085 | 4,035 | 14,119 |

Note: Figures calculated prior to rounding

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-178

OUTCOME 5: RURAL HEALTH

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

(a) How many actual placements have trainees completed in rural Australia and how has this increased in recent years?
(b) What has been the outcome in 2003 for the number of trainee's places available in each region and the number actually being taken up?

Answer:

(a) Since the introduction of the rural training pathway in 2000 the number of rural placements being completed by trainees has been steadily increasing over time:
- 2000 – 722 actual placements were completed;
- 2001 - 1,010 actual placements were completed; and
- 2002 - 1,560 actual placements were completed.

(b) The number of trainee places in each region and the take up for 2003 is as follows:

| **Training Provider** | **Places Allocated** | | **Places Filled** | |
|---|---|---|---|---|
| | **Rural** | **General** | **Rural** | **General** |
| Adelaide to Outback | 10 | 7 | 8 | 10 |
| Bogong Regional Training Network | 10 | 2 | 11 | 2 |
| Coast City/Country Training | 15 | 9 | 15 | 10 |
| Central & Southern Old Training Consortium | 20 | 35 | 20 | 37 |
| Central West NSW Consortium | 8 | 3 | 9 | 4 |
| Greater Green Triangle GP Training | 12 | 0 | 13 | 0 |
| GPETGP (Gippsland) | 12 | 0 | 14 | 0 |
| Institute for General Practice Education | 0 | 21 | 0 | 22 |
| North Coast NSW | 8 | 2 | 6 | 2 |
| New England Area Training Services | 9 | 1 | 7 | 1 |
| Northern Territory GPE | 9 | 3 | 10 | 1 |
| Rural & Regional Qld Consortium | 18 | 4 | 15 | 2 |
| Sydney Institute for GP Education & Training | 0 | 20 | 0 | 21 |
| Sturt-Fleurieu GP Training | 10 | 7 | 9 | 7 |
| Tasmanian GP Training | 7 | 5 | 7 | 5 |
| Tropical Medical Training | 10 | 10 | 7 | 10 |
| Valley to Coast | 3 | 20 | 3 | 20 |

| | | | | |
|---|---|---|---|---|
| Victoria Felix Medical Education | 16 | 4 | 16 | 4 |
| Victorian Metropolitan Alliance | 0 | 59 | 0 | 59 |
| WAGPET | 25 | 28 | 13 | 25 |
| Wentwest | 0 | 21 | 0 | 21 |
| Western NSW GP Training | 9 | 1 | 7 | 2 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-179

OUTCOME 5: RURAL HEALTH CARE

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

How many appointments have been made for the Clinical assistantships created in 1999 to increase the number of surgeons in rural Australia?

Answer:

The Clinical Assistantship Program (CAP) was the safety net arrangement agreed between the associations representing doctors-in-training and the then Commonwealth Department of Health and Family Services at the time of the introduction of new Medicare provider number legislation in 1996. The Department guaranteed that any doctor unsuccessful in obtaining a medical training position would be given the opportunity to take up a CAP position in a rural area of need.

The Mid-Term Review of the provider number legislation, which reported to the then Minister for Health and Aged Care, Dr Michael Wooldridge on 22 November 1999, found that there was no instances of a junior doctor failing to find a training place and that there had been no applications for this program. There has also been no applications since.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-180

OUTCOME 5: RURAL HEALTH CARE

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

How many doctors are currently on the Register of Medical Opportunity?

Answer:

None. Provision for the Register of Medical Opportunity was made at the time of introduction of new Medicare provider number legislation in 1996 due to concerns about junior doctors' access to medical training places.

The Mid-Term Review of this provider number legislation, which reported to the then Minister for Health and Aged Care, Dr Michael Wooldridge, on 22 November 1999, found that there was no instances of a junior doctor failing to find a training place. Greatly improved data on training places provided by the Medical Training Review Panel (MTRP) since 1997 in its annual reports show that there are more than enough training places for junior doctors. As a consequence, the MTRP has not received requests from any doctor seeking to be placed on a Register.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-181

OUTCOME 5: RURAL HEALTH CARE

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

How many new doctors are currently serving in rural Australia as a result of the Rural Bonded Scholarships?

Answer:

All participants in the Medical Rural Bonded Scholarships Scheme are still studying medicine at universities around Australia. Since 2001, 100 Medical Rural Bonded Scholarships have been awarded annually to first year medical students. These students are not required to work in rural Australia until they have completed their medical course, internship and fellowship training.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-182

OUTCOME 5: RURAL HEALTH

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

(a) How many GPs in each of the categories of rural areas are now receiving incentive payments under the Rural Incentives Program?
(b) How many of these doctors have moved into a rural area from an urban area since starting to receive these payments?

Answer:

(a) Since the commencement of the program around 2,412 doctors have received retention payments. Numbers of doctors who have received these payments according to different categories are as follows:

| Retention Payment Category & Qualifying Period | No. of doctors |
|---|---|
| A 6 years | 819 |
| B 5 years | 863 |
| C 3 years | 312 |
| D 2 years | 137 |
| E 1 year | 281 |
| Total | **2,412** |

(b) Only rural doctors who have been in an eligible area for a qualifying period receive these payments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-183

OUTCOME 5: RURAL HEALTH CARE

Topic: RURAL MEDICAL WORKFORCE

Written Question on Notice

Senator McLucas asked:

How many overseas doctors in each State have been approved under the new arrangements announced in early 1999? How many of these doctors are now currently practicing in rural areas and how many have transferred their activates to non rural areas?

Answer:

As of 28 February 2003 the number of overseas trained doctors approved in each State and the Northern Territory to work under the arrangements approved by the Australian Health Ministers Council in 1999 is 187. Current figures for each State and the Northern Territory are as follows:

| | |
|---|---|
| New South Wales | 15 |
| Northern Territory | 4 |
| Queensland | 21 |
| South Australia | 4 |
| Tasmania | 11 |
| Victoria | 63 |
| Western Australia | 67 |
| **TOTAL** | **185** |

One of the two doctors that have left the Scheme has returned to the United Kingdom and the other doctor continues to work in a rural location.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-017

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PETROL SNIFFING

Written Question on Notice

Senator Crossin asked:

Can the Department provide an indication of the numbers served by the programs outlined in responses to questions E02-021 to E02-025?

Answer:

Programs referred to in questions E02-021 to E02-025, including approximate numbers served by these programs, are:

*OATSIH Substance Use Program*
Of the $21 million committed to addressing Aboriginal and Torres Strait Islander substance use through the OATSIH Substance Use Program, approximately $1,577,228 is allocated towards activities addressing petrol sniffing:

- $577,228 towards three petrol sniffing programs in Central Australia. Between 120 and 160 people use these facilities each year. Not all clients are people who currently sniff petrol.
- The Commonwealth continues to resource the Comgas Scheme. The Scheme was established by the OATSIH in 1998, whereby the Commonwealth subsidises the supply of aviation fuel, or Avgas, to participating communities, as part of a harm reduction strategy to address petrol sniffing. This subsidy takes the form of an excise to the relevant oil company to provide aviation fuel, at road fuel rates, to those communities involved. There are currently 33 communities participating in the Scheme.

*National Respite for Carers Program (NRCP)*
The National Respite for Carers Program (NRCP) supports an administrative Framework for respite that includes a National Commonwealth Carer Resource Centre, 63 Commonwealth Carer Respite Centres, and over 400 Commonwealth Carer Respite Services. Carers of people with disabilities resulting from petrol sniffing access the respite services provided by the Central Australian Cross Border Region Commonwealth Carer Respite Centre which receives funding under this program. The Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council operates the centre. From July 2002 to February 2003, 114 carers received respite services provided by the Central Australian Cross Border Region Commonwealth Carer Respite Centre. It is not possible to provide accurate information on the number of care recipients disabled by petrol sniffing. However, around 48 carers of people with Acquired Brain Injury were assisted. The centre will receive $187,694 in 2002/2003.

*National Illicit Drugs Strategy Non-Government Organisations Treatment Grants Program*
Under the National Illicit Drug Strategy, Non Government Organisations Treatment Grants Program, the Commonwealth funds a petrol sniffing project in the cross border region of WA, SA and the NT through the Ngaanyatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council. Under this program families are assisted to deal with the impact of petrol sniffing including gaining access to respite services and receiving practical support. The Department is unable to access information on the number of people served by this program. This project will receive $187,316 in 2002/2003.

*Prime Minister's Petrol Sniffing Diversion Project-Northern Territory*
Of the $2.7 million allocated to the Northern Territory under the COAG Illicit Drug Diversion Initiative, $1million has been made available for programs to address petrol sniffing in the Northern Territory. Three projects are currently underway in Central Australia and the Top End. The petrol sniffing projects in the NT are all prevention projects aimed at all young people at risk in communities. The projects have a prevention, early intervention and diversion focus. The projects are *not treatment based* and therefore quantitative measures on numbers of sniffers involved and numbers of re-offenders are not currently part of the formal reporting requirements. To date, $389,115 has been paid towards these projects.

**Department of Family and Community Services**

*Buddies Program*
The Buddies Program, a collaboration between the Department of Family and Community Services and the Aboriginal and Torres Strait Islander Commission, supports employment and participation opportunities for young Aboriginal and Torres Strait Islander people living in remote communities who were affected by substance use, specifically, petrol sniffing. There are currently 40 places funded through this program (WA – 10, NT – 20 and SA – 10) however utilisation of these places varies. In 2002/2003 this project will receive $240,000.

*Disability Supported Employment Program*
This program aims to provide supported employment for people with a disability, including those who have a disability as a result of petrol sniffing. There are 5 Aboriginal and Torres Strait Islander specific services that receive funding under this program. While figures vary, there are currently three people supported by this program in the cross border region of Central Australia. Funding for these projects in 2002/2003 is $522,358.

*Carer Respite Centres*

Family and Community Services funding for Carer Respite Centres complements that provided by the Department of Health and Ageing under the National Respite for Carer's Program. It is intended to provide respite for carers of young people with severe or profound disabilities, including those people who have a disability as a result of petrol sniffing. In the Central Australian region, the Ngaanyatjarra Pitjantjatjara Yankunytjatjara Women's Council (NPYWC) received $10,129 under this program. From July 2002 to February 2003, 114 carers received respite services provided by the Central Australian Cross Border Region Commonwealth Carer Respite Centre. It is not possible to provide accurate information on the number of care recipients disabled by petrol sniffing. However, around 48 carers of people with Acquired Brain Injury were assisted.

*Disability Advocacy Program*

The aim of this program is to identify gaps in service provision and offer information on equipment and advocacy support to people with disabilities, including those who have a disability as a result of substance use. Case management services are also offered under this program. In the Central Australian region, the Cross Border Advocacy Program (NPYWC) will receive $106,052 in 2002/2003 under this program. There are approximately 50 people utilising this program at present.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-018

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PETROL SNIFFING

Written Question on Notice

Senator Crossin asked:

Is the final report of the Review of Three Petrol Sniffing Programs in Central Australia by Network Australia available? If so can you provide a copy?

Answer:

The final Report of the *Review of Three Petrol Sniffing Programs in Central Australia* by Network Australia, was received by the Northern Territory Office of the Department of Health and Ageing on 22 November 2002. The Department has made undertakings to the communities involved not to distribute the Report. A de-identified summary of the report has been prepared for the Senator's information (Attachment A).

**ATTACHMENT A**

# Review of Petrol Sniffing Programs in Central Australia

## NETWORK AUSTRALIA CONSULTING PTY LTD, NOVEMBER 2002

## OATSIH Summary

### Background

In June 2001, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Ageing (the Department) commissioned Network Australia Consulting Pty Ltd to undertake an evaluation of three substance misuse programs in Central Australia for their effectiveness in reducing the prevalence of, and harm from, petrol sniffing. In the year under review, 2000-2001, OATSIH provided a total of $545,420 to these programs and other funding agencies contributed $200,000.

**Terms of Reference**

The overall objective of the evaluation was to:

assess the effectiveness, efficiency and appropriateness of programs (3) funded by OATSIH in reducing the prevalence and harm associated with petrol sniffing within Central Australia.

This objective was expanded during the latter stages of the review to also consider the programs in relation to other funding agencies.

The review was required to provide:

- identification and assessment of the range of interventions offered by each program, including a detailed description of the service area (i.e. both geographic and cultural) and assessment of any recent or proposed change in the scope of existing services;

- identification and analysis of relevant data and evidence concerning the effectiveness of current interventions (as identified above) in reducing the prevalence and harm associated with petrol sniffing, including the identification of those factors which influence the success or otherwise of those interventions;

- identification and assessment of staffing and other operational requirements for the delivery of **existing** services with particular reference to *duty of care*, including indicative costings to address identified gaps and deficiencies;

- recommendations for improving the appropriateness, effectiveness and sustainability of existing programs, including indicative costings for implementation of service enhancements and the development of appropriate performance indicators;

- identification and assessment of program management systems with particular reference to strategic and business planning, staff training and supervision, data collection, case management and quality assurance and collaboration with other substance misuse services/broader health services within the region; and

- a critical analysis of relevant recommendations of the report of the coronial inquest into the death of a young petrol sniffer during October 1994 and a detailed assessment of the extent to which these recommendations have (or have not) been addressed ([8]).

The consultancy involved:

- an extensive field trip to Central Australia

- three additional visits to Alice Springs, conducted in July and September of 2001 and February 2002

- analysis of project files, statistics and other written information on each program

- semi-structured and unstructured interviews with stakeholders from remote communities, in Alice Springs and in Darwin

- relevant research and other reports on petrol sniffing

- a 'Pathways Forum' of government funding agencies held in Alice Springs in February 2002.

All communities have tried various strategies to prevent or reduce petrol sniffing, with varying degrees of success. There is ongoing concern from people in these communities to address the issue.

While the context for the programs might be similar, there are significant differences in the approaches used within each service to deal with petrol sniffing and other substance misuse.

[8] *Summary of Principal Findings Esky Muller AKA Armstrong*, NT Coroner's Office No. A82/94

***Program A***
This program operates in both the home community and an outstation and has three components involving prevention, early intervention and rehabilitation:

- activities within the home community, such as sports and a regular and frequent disco open to all young people

- foot patrols of the home community by the Program Manager

- the isolation at an outstation of young people who have been sniffing petrol. This allows the them to 'dry out', provides a deterrent and gives the community respite from the behaviours often exhibited by young people sniffing petrol – violence, noise and crime, usually breaking and entering.

On average, there are about five young people at the outstation per day. The outstation component operates for around nine months of the year and closes over the wetter months.

***Program B***
This program offers respite or refuge and counselling at an outstation for people with substance misuse problems. It has, in the past, been involved in festivals, events and activities aimed at strengthening communities and sharing information. More recently, it decided to shift its focus to services for women wishing to recover from violence or other abuse, while continuing to work with people with substance misuse problems.

On average, around 40 people per year use the facility. The majority of clients are self-referred from the home community and come seeking either refuge, for example from violence, or to 'dry out' and overcome a substance abuse problem, usually alcohol. Few petrol sniffers have been involved in the program in recent years.

***Program C***
This program is different from the other two in that participants come from more than one community and are required to learn skills such as mustering, welding, repairing bores and cars, working with horses and so on. The service has a greater emphasis on rehabilitation than the other two.

Most current program participants are referred by the courts, although some are self-referred. Many have been involved in violent crimes, often where substance abuse, usually alcohol, has been a factor. Most people are in their early 20s. Few young petrol sniffers use the program. Participants are often taken into Alice Springs for court appearances.

No data on the people at the outstation is kept by either referring agencies or the program itself. Based on the number of people currently participating in the program, together with interviews, the review estimated that the program dealt with an average of 40 clients per year.

**Evaluation of the services**

The three services were evaluated using criteria covering the relevant Terms of Reference:

- The impact of the program on reducing the prevalence or harm associated with petrol sniffing in the catchment area
- The impact of the program on reducing the prevalence or harm associated with substance abuse
- Support for the program from stakeholders.
- The quality of corporate governance, including community oversight, accountability and ownership of the program.
- Program management - strategic and business planning, staff training and supervision, data collection, case management, quality assurance and collaboration with other substance abuse services were considered.
- Financial management
- Compliance with Coroner Donald's recommendations.

***Program B***

Most clients at this service have had problems with alcohol misuse. The service's involvement in festivals and events have strengthened communities and had positive outcomes. The organisation recently decided to shift its focus to women recovering from violence or other abuse. There is little evidence of participation from nearby communities. There are problems and deficiencies in governance and program and financial management, but there is staff training, liaison with other agencies and strategic planning. Compliance with Coroner Donald's recommendations is incomplete ie not all those who operate the facility have appropriate first aid qualifications.

***Program C***

Few of the clients at this service were petrol sniffers, but the program has had a positive impact on substance misuse. There is little evidence of support and participation from nearby communities, but community-based agencies suggest it as an option to the courts. There are problems and deficiencies in governance and program management, but financial management appears adequate. Compliance with Coroner Donald's recommendations is incomplete ie this service has only partially adequate facilities in terms of communications and first aid.

The following are considered to be key components of programs of this nature. There is presently some variability in the extent to which each of the programs meet these and the review recommended that they be addressed:

***Health and safety of clients***

- staff must hold current first aid certificates at the appropriate level
- staff should be required to ring or radio the home community or referring agency daily to confirm the ongoing safety of participants
- clients referred by an agency must be medically assessed before being taken to an outstation
- an audit of the facilities is required to identify areas where occupational health and safety provisions are inadequate.

***Case management and information collection***

- simple records need to be kept on each individual who attends, including name, health check status, length of stay and behaviour
- weekly statistics on the number of clients should be maintained, including names of all participants, referring agency, reasons for referral and length of stay
- data collected can be used to inform performance measures
- the confidentiality of personal information must be ensured through appropriate storage

***Governance and business planning processes***

- staff and management committee members should receive basic training on governance issues covering the legal, financial and reporting responsibilities of management committee members.
- the services need to develop strategic and business plans, taking into account current regional initiatives such as the *Central Australian Regional Substance Misuse Strategic Plan* [9] and the Youth Link-Up Service (YLUS).

[9] Central Australian Regional Indigenous Health Planning Committee, *Central Australian Regional Substance Misuse Strategic Plan,* Australian Government Publishing Service, Canberra, 2001

***Working together and maintaining linkages***

- each agency needs to develop and maintain linkages with other agencies working in addressing petrol sniffing or other substance misuse, and stay abreast of developments

- staff should be required to allocate a proportion of time to this activity.

Following the workshop between Network Australia consultants and government stakeholders (Commonwealth Department of Family and Community Services, Commonwealth Department of Health and Ageing, NT Department of Health and Community Services, Northern Territory Correctional Services, Northern Territory Police, and the Juvenile Diversionary Unit), held in February 2002, four "key learnings" for these programs were identified:

- the need for coordinated and integrated program development and delivery, at government and community levels as well as across the region

- recognition that solutions come from communities and families working in partnership with governments

- program priority should be towards enhancing life skills of individuals and families, including inter-generational learning

- there needs to be an increased focus on long-term outcomes.

The Department will discuss with the three services/communities individually the future of each program in the light of the conclusions and recommendations of the review. These discussions will take into account the changing needs and priorities of the communities and the relative importance of petrol sniffing in services that have to date been funded to address substance misuse.

The Department will ensure that the key recommendations of the review in the areas of health and safety of clients, case management, governance and accountability are implemented by these and any similar services that may be funded in future.

The Department will bring all three services together to meet with other Central Australian organisations concerned with substance misuse. Discussions will centre on information sharing and consideration of integrating the services into a regional network with appropriate support and referral mechanisms. Other communities in the region would be encouraged to join the regional network.

In partnership with the Department of Family and Community Services (FaCS), other Commonwealth and NT government agencies and non-government agencies, the Department will work to facilitate the sustainable provision of activities for both young and working age people in remote communities. These can help prevent or divert young people from substance misuse or from starting again after a period of drying out, as well as improving well-being and forming the basis for a healthy lifestyle.

The Department will support the Central Australian Cross Border Reference Group on Volatile Substance Use in the development of an action plan to address issues of volatile substance use common to South Australia, Western Australia and the Northern Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-019

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

Written Question on Notice

Senator Crossin asked:

a) Is it correct that the Commonwealth will provide longer term funding for the Workforce Information Program (WIP) for the period January 2003 to June 2004?
b) What is planned for after June 2004 with the funding of this program? Is the Commonwealth expecting the States to fund this program?
c) Can the Department outline what is being planned?
d) Does this include cost shifting and if so why is this being planned?
e) Have negotiations begun with the States and Territories?

Answer:

a) That is correct.

b) The Commonwealth will request State and Territory governments to consider providing funding for WIPOs as part of affiliate core funding after June 2004.

c) Where possible, negotiations will be undertaken before July 2003.

d) This is not cost shifting. Under the Aboriginal health framework agreements State and Territory level activity undertaken by NACCHO affiliates should be funded by the State and Territory governments. For example, the Commonwealth provides core funding to NACCHO and State and Territory governments provide core funding to state-based NACCHO affiliates. However, where specific time-limited activity is required OATSIH can and does provide funding directly to the State and Territory NACCHO affiliates for national purposes. WIPO funding to address the Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework is an example.

e) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-020

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER WORKFORCE

Written Question on Notice

Senator Crossin asked:

a) Correspondence dated December 12, 2002 from OATSIH to State affiliates of NACCHO outline OATSIH expectations with respect to the continued funding of the WIPO Network. Was this outline prepared as a policy statement or a consultation paper, or as the basis for continued discussion?
b) Will there be further consultation with the State and Territory affiliates on this document?
c) Is it intended that WIP Officers no longer remain at the sole direction and control of the NACCHO State and Territory affiliates?
d) If yes, why has OATSIH made this unilateral decision?

Answer:

a) The document is a policy proposal on the central role OATSIH would like to see the WIPOs, with the support of the partners, undertake over the next 18 months.

b) The Commonwealth is happy to negotiate with affiliates and WIPOs over how this new direction might be undertaken, and how it would be combined with their current roles.

c) WIPOs will continue to be employed and directed by affiliates. Workforce Strategic Framework development work should however be undertaken in partnership through Forum processes and consistent with consensus-based decision making processes. The Commonwealth is keen to ensure that with support WIPOs play a central driving role in Framework implementation in each jurisdiction.

d) Not relevant.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-021

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: IMMUNISATION SERVICES TO ABORIGINAL COMMUNITIES

Written Question on Notice

Senator Crossin asked:

(a) What is the current funding level for the National Indigenous Pneumococcal and Influenza Immunisation Program?
(b) Over the past 6 years, what has been the level of funding and the level of expenditure for this program?
(c) What are the goals of this program with respect to the percentage of children in remote communities that are immunised?
(d) What are the actual numbers of children vaccinated?
(e) What is the incidence of pneumococcal disease in these remote communities? How does this compare with the Australian average?
(f) What measures have been adopted to ensure that all children are vaccinated?

Answer:

(a) The current projected funding for the National Indigenous Pneumococcal and Influenza Immunisation (NIPII) program for the 2002/03 financial year is $2.4 million.

(b) This program has been in operation since the 1998-99 financial year. Figures below are totals of funding provided to States and Territory Governments to conduct adult vaccinations and totals of actual expenditures as reported by States and Territory Governments.

| *Year* | *Levels of funding (NIPII program)* | *Actual expenditures by States and Territories on NIPII vaccines* | *Rollovers of unspent funds by States and Territories* |
|---|---|---|---|
| 98/99 | $4,588,469 | $2,958,696 | $1,619,773 |
| 99-00 | $429,018 | $1,770,606 | $278,185 |
| 00-01 | $1,662,763 | $1,685,054 | $255,894 |
| 01-02 | $1,727,306 | $1,358,615 (still awaiting several acquittals) | To be determined |
| 02-03 | $2,400,000 | still subject to negotiation | |
| *Total* | $10,807,556 | $7,772,971+ | |

(c) The National Childhood Pneumococcal Vaccination Program aims to reduce rates and severity of pneumococcal disease in high risk childhood populations in Australia and provides access to free pneumococcal conjugate vaccine for children considered at highest risk from invasive pneumococcal disease. The Program, which was endorsed by the National Health and Medical Research Council (NHMRC) and added to the Australian Standard Vaccination Schedule (ASVS) in 2001, targets four main groups:

- all Aboriginal and Torres Strait Islander children (aged under 2 years);
- Aboriginal children in Central Australia and any region likely to have a similar very high incidence of pneumococcal infection (aged 24-59 months);
- non-Aboriginal children in Central Australia (aged under 2 years); and
- children under 5 years of age with medical risk factors that predispose them to high rates or high severity of pneumococcal infection.

The National Indigenous Pneumococcal and Influenza Immunisation (NIPII) Program for adults utilises a polysaccharide pneumococcal vaccine Pneumovax 23®, which is not suitable for children under 18 months of age. The advent of a conjugate pneumococcal vaccine Prevenar® in December 2000 allowed a childhood pneumococcal vaccine program for the 0-5 age groups to be introduced.

The Commonwealth provides funding for State and Territories to purchase pneumococcal vaccine for 95% of the eligible cohort. As the children eligible for free vaccine under this program are very difficult to target, the Commonwealth has not set a target coverage figure. However, States and Territory Governments are required to show, as part of the Public Health Outcome Funding Agreements, that coverage of the target group is increasing.

(d) As at 20 February 2003, a total of 28,737 children have received a dose of pneumococcal vaccine. Of these, 10,282 children (36%) have consented to being identified as an Aboriginal or Torres Strait Islander on the Australian Childhood Immunisation Register (ACIR). The Commonwealth, in partnership with the States and Territory Governments and the Aboriginal community controlled health sector, is working to improve the level of identification of Aboriginal and Torres Strait Islander status on the ACIR.

(e) The incidence of Invasive Pneumococcal Disease in Indigenous children under five years of age in Central Australia, defined as the area serviced by Alice Springs Hospital which includes parts of northern South Australia and eastern Western Australia as well as the southern Northern Territory, is 1,500 per 100,000 (in 2000). This is 15 times higher than the rate in non-Indigenous children living in urban areas of Australia.

Indigenous children under two years of age living in the Northern Territory outside Central Australia and in desert or tropical regions of Queensland, Western Australia and South Australia, particularly in rural and remote settings have up to 4 times higher incidence of Invasive Pneumococcal Disease than non-Indigenous children

(f) The Commonwealth has provided promotional material to all States and Territories for distribution, which targets both immunisation providers and parents of eligible children. A Rural Health Satellite Broadcast about the program, targeting general practitioners, nurses and Aboriginal Health Workers, was funded by the Commonwealth Government and broadcast in May 2001. This promotional material aims to increase awareness of the program and outlines the eligible target groups.

The Commonwealth has also worked with the States and Territories and immunisation providers through the National Immunisation Committee, which also has representation from the Australian Divisions of General Practice and Royal Australian College of General Practice, to improve identification of Indigenous children by immunisation providers. The States and Territories continue to implement local initiatives to improve pneumococcal vaccine coverage within their respective jurisdictions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-022

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE MISUSE

Written Question on Notice

Senator Crossin asked:

a) How much money is specifically allocated through the Commonwealth Department of Health and Ageing on substance misuse initiatives directly targeting Aboriginal & Torres Strait Islander peoples?
b) How much of the total expenditure is allocated to Aboriginal Community Controlled Health Services?

Answer:

a) The Department of Health and Ageing provides funding to address Aboriginal and Torres Strait Islander substance use through the Office for Aboriginal and Torres Strait Islander Health, the Population Health Division and the National Health and Medical Research Council.

The OATSIH approach to substance use sits within an overall framework for substance use and involves:

- supply initiatives (such as substitution of Avgas for petrol);
- prevention (such as education or sport and recreation programs);
- early intervention (such as night patrols, counselling and outstation programs; and
- treatment approaches (residential rehabilitation, group work, counselling).

The OATSIH Substance Use Program administers approximately $21 million to address Aboriginal and Torres Strait Islander substance use. This funding is comprised of:

- $16.4 million to support 67 Aboriginal and Torres Strait Islander substance use services nationally. Forty three of these services are stand alone substance use services with the remaining 24 funded as part of Aboriginal and Torres Strait Islander primary health care services.

- $3.5 million managed at a national level to support the development of research, infrastructure and resources to address substance use.
- $1 million to administer the Comgas Scheme. The Comgas Scheme subsidises the supply of Avgas to Aboriginal communities using aviation fuel as part of a harm reduction strategy to address petrol sniffing.

**Population Health Division**

***National Drug Strategy Complementary Action Plan for Aboriginal and Torres Strait Islander People***

The Department is facilitating, on behalf of the Ministerial Council on Drug Strategy, the development of a National Drug Strategy Action Plan for Aboriginal and Torres Strait Islander peoples. It is anticipated that the Action Plan will be considered by the Ministerial Council on Drug Strategy in August 2003, including consideration of implementation issues. The cost so far in the 2002-03 financial year associated with developing the Action Plan is $97,347.

*National Illicit Drugs Strategy Non Government Organisations Treatment Grants Program*

Under the National Illicit Drugs Strategy, Non-Government Organisations Treatment Grants Program, the Commonwealth has allocated a total of $8, 640, 319 (over four years) to 18 drug and alcohol treatment projects that provide services specifically to Aboriginal and Torres Strait Islander people. Of this, $2, 076, 570 will provided in 2002/2003.

*Community Partnerships Initiative*

The Community Partnerships Initiative aims to encourage quality practice in community action to prevent illicit drug use and to build on existing activity occurring across Australia. To date, 135 projects, to a total value of $10.5 million have been funded nationally under three funding rounds. Of these, 18 projects focus on Aboriginal and Torres Strait Islander People. These projects will receive $257,275 in 2002/2003.

*Training Front Line Workers Initiative*

Under the National Illicit Drug Strategy, Training Frontline Workers Initiative a contract has been let with the Aboriginal Drug and Alcohol Council (SA) for the development of a national training resource to increase the skills and knowledge of Aboriginal and Torres Strait Islander workers who come into contact with clients affected by illicit drugs and/or other substances. Funding to be provided to this project in 2002/03 is $122,898.

*NT Research on cannabis use and harms in remote Aboriginal Communities*

As part of the Council of Australian Governments (COAG) commitment to further strengthen the National Illicit Drug Strategy, $1.179 million (over four years) has been allocated for the development of cannabis cessation initiatives. This includes the expansion of an Aboriginal and Torres Strait Islander research project recently funded by the National Health and Medical Research Council through the National Illicit Drug Strategy Research Program. The project is researching the patterns of cannabis use before and after implementation of an education intervention designed for local cultural and linguistic needs in two Aboriginal communities, and is due for completion in early 2003**.** Funding to be provided to this project in 2002/03 is $105,420.

*Aboriginal and Torres Strait Islander Tobacco Project*
$1 million package of targeted measures as an initial step towards addressing tobacco use by Aboriginal and Torres Strait Islander people was announced by Minister Patterson on 31 May 2002 in response to the report of the NACCHO Tobacco Project (funded under the National Tobacco Strategy). Tenders were called for in the national and Indigenous press, advertised in the Commonwealth Gazette and details made available on the Department's website in December 2002. Closing date for tenders is 28 February 2003.

The three elements of the tender package are:

- Development of an Indigenous tobacco control clearinghouse or centre of excellence;
- Work around smoking and Indigenous health workers; and
- Development of a culturally appropriate indigenous tobacco control resource.

*COAG Illicit Drug Diversion Initiative*
The Department is providing $103 million over 4 years (1999/2000 to 2002/03) to the States and Territories to implement the COAG Illicit Drug Diversion Initiative. Under this initiative, "preferred providers" are approved to provide education, assessment and treatment to clients who are diverted to treatment by either the police or courts. Providers may receive retainer funding and/or funding on a fee-for-service basis. Approval of providers and retainer funding is based on identified priorities in each State and Territory and may include Indigenous-specific services for Aboriginal and Torres Strait Islander clients. In the absence of Aboriginal and Torres Strait Islander services (or if client choses not to attend an Aboriginal and Torres Strait Islander service), education, assessment and treatment will be provided through mainstream services.

*PM's Petrol Sniffing Diversion Project - Northern Territory*
Of the $2.7 million allocated to the Northern Territory under the COAG Illicit Drug Diversion Initiative, $1 million has been made available for programs to address petrol sniffing in the Northern Territory. Three projects are currently underway in Central Australia and the Top End and to date $389,115 has been paid to these services.

**National Health and Medical Research Council**

The National Health and Medical Research Council's (NHMRCs) Strategic Research Development Committee (SRDC) targeted illicit drug use in Indigenous communities in its calls for research under the National Illicit Drug Strategy Program (NIDS) in 2000. Three projects received funding, two of which are currently funded:

- Tied Grant *Heavy Cannabis Use in Two Remote Aboriginal Communities: Prospects for a Population Based Intervention* (Chief Investigator: Mr Alan R Clough, Menzies Centre for Population Health Research). This project commenced in 2001 and will receive total funding of $301,814 over three years.

- Tied Grant *An Analysis of needs of Indigenous Illegal Drug Users in the ACT and Region for Treatment and Other Services* (Chief Investigator: Dr Phyll Dance, The Australian National University). This project commenced in 2001 and will receive total funding of $240,905 over three years.

- The NHMRC is also funding a Project Grant *The Policy Response to Indigenous Petrol Sniffing – and How to Improve It* (Chief Investigator: Dr Peter HN d'Abbs, Menzies School of Health Research). This project commenced in 2002 and will receive total funding of $105,770 over two years.

- The NHMRC has approved funding for a second Project Grant, to commence funding in 2003, that involves research that targets substance misuse in Indigenous communities.

- Project Grant A randomized Trial of the Impact of a Multi-intervention Anti-tobacco Strategy in 8 Indigenous Communities. This project has three broad aims:
  - to increase the capacity of health services to implement and deliver anti-tobacco interventions;
  - – to increase community knowledge and awareness of the risks of smoking; and
  - –to decrease the level of tobacco consumption within communities.

This project will receive total funding of $567,750 over three years.

b) All of the services funded under the OATSIH Substance Use Program are Aboriginal and Torres Strait Islander community controlled. Other programs/projects described above operate under a variety of arrangements including collaborations between community controlled organisations and/or non-Indigenous organisations, and/or the Commonwealth government and/or State and Territory governments. It is not possible to accurately attribute percentages of funding provided by all parties.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-023

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE MISUSE

Written Question on Notice

Senator Crossin asked:

As a result of the Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program – Final Report (December 1999), can you please outline the strategic policy approach (identified at 3.1 and 3.2 as priority for action) developed and what has this meant in dollar terms to increases in funding to ACCHS?

Answer:

The Department's approach to addressing Aboriginal and Torres Strait Islander substance use operates within a framework which supports access for communities to services across the care continuum, from prevention and early intervention, to clinical care and treatment.

A range initiatives have been implemented in response to the *Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program* including:

- collaborative arrangements with a range of partners including State and Territory Governments, ATSIC and the community controlled sector, for example the Central Australian Cross Border Reference Group on Volatile Substance Use;
- incorporation of substance use needs and issues into regional planning processes;
- the Quality Assurance Pilot Project of South Australian substance use services; and
- increasing effort and resources directed at prevention and early intervention approaches.

Since the Review, funding under the Substance Use Program to Aboriginal Community Controlled Health Services (ACCHS) has increased by $1,225,967 from $2,935,970 (1999/00) to $4,161,937 (2002/03). Additionally, ACCHS access funding from other Departmentally administered programs.

In addition, key aspects of Commonwealth policy in regard to Aboriginal and Torres Strait Islander substance misuse are informed by the National Drug Strategy.

The *National Drug Strategy* advocates a comprehensive and balanced approach based on a range of partnerships and the utilisation of harm minimisation strategies. It advocates the need to take a wide range of approaches in dealing with drug-related harm, such as supply, demand and harm reduction strategies.

*The National Drug Strategy's Aboriginal and Torres Strait Islander Complementary Action Plan* is currently being drafted under the auspices of the National Drug Strategy Reference Group for Aboriginal and Torres Strait Islander Peoples. It is expected to reach the Ministerial Council on Drug Strategy for endorsement later in 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-024

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE MISUSE

Written Question on Notice

Senator Crossin asked:

The policy framework for the development of Indigenous substance misuse services at that national level needs to be centred around a strong network of comprehensive primary health care services which encompass population health and clinical care services. Why is NACCHO unable to receive funding for the plan it has developed to strengthen the work and networks of the ACCHS sector?

Answer:

- *The National Strategic Framework for Aboriginal & Torres Strait Islander Health* (endorsed by Federal Cabinet on 3 February 2003) is a key guiding policy document for the Department. It makes clear the central role for primary health care services, as did the *Review of the Commonwealth's Aboriginal and Torres Strait Islander Substance Misuse Program*.

- The Department has developed partnerships with a range of stakeholders, including NACCHO and the National Indigenous Substance Misuse Council, and values the contribution of a range of stakeholders, including stand-alone services, State and Territory Governments, and the Aboriginal Community Controlled Health Sector, as represented by NACCHO and its affiliates.

- NACCHO, as the peak body for Aboriginal community controlled health services, has a critical role to play in the development of sustainable responses to alcohol and other drug issues within a comprehensive primary health care context.

- The Department currently provides funding of approximately $1.8 million annually to NACCHO as a global budget. NACCHO sets the priorities for the use of this amount.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-025

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: EXPENDITURE ON ABORIGINAL HEALTH

Written Question on Notice

Senator Crossin asked:

a) Could you provide a breakdown of current Aboriginal Health expenditure provided through the Department of Health & Ageing?
b) What is the total budget provided to the Office of Aboriginal & Torres Strait Islander Health (OATSIH)?
c) Please provide a breakdown of the OATSIH budget: how much of the budget is spent on:
   i) the OATSIH itself
   ii) the Aboriginal Community Controlled Health Sector
   iii) universities and TAFES
   iv) consultancies

Answer:

a) During 2002-03 it is estimated that $288.3 million will be spent on Indigenous-specific initiatives by the Department of Health and Ageing. A breakdown of this estimated expenditure is as follows:

| **Program/project** | **$M** |
|---|---|
| Croc Festivals | 1.6 |
| Diversion/Illicit drugs Intervention – Petrol sniffing diversion pilot program | 0.4 |
| National Illicit Drugs Strategy Non-Government Organisations Treatment Grants Program | 2.1 |
| National Child Nutrition Program – Indigenous round | 1.7 |
| Indigenous Injury Action Plan and Workshop | 0.1 |
| Public Health Community Partnerships Initiative | 0.3 |
| Public Health Training Front Line Workers Initiative | 0.1 |
| Public Health NT Research on Cannabis Use and Harms in Remote Aboriginal Communities | 0.1 |
| Alcohol Strategy Team | 4.3 |
| Section 19(2) Exemptions for Aboriginal Medical Services under the Health Insurance Act | 12.9 |
| Aged Care Strategy for Aboriginal and Torres Strait Islanders – Residential Care | 13.1 |

| | |
|---|---|
| Alternative Arrangements for the Delivery of Pharmaceutical Benefits under S100 of the National Health Act | 15.0 |
| Health Programme Grants – General Practice Services Rural and Remote Areas of the Northern Territory (1) | 0.4 |
| Health services in Aboriginal and Torres Strait Islander Communities | 180.1 |
| Aboriginal and Torres Strait Islander Primary Health Care Access Program | 20.8 |
| Infrastructure to support the development and operations of high quality health care services | 18.5 |
| Improving living conditions in remote communities – ATSIC/Army Community Assistance Program | 4.3 |
| Fringe Benefits Tax supplementation for Aboriginal and Torres Strait Islander health | 7.2 |
| Fringe Benefits Tax supplementation for Aboriginal and Torres Strait Islander Aged Care | 0.1 |
| Indigenous research grants | 5.2 |
| Total | 288.3 |

(1) The Northern Territory District Medical Officer Service is not specifically targeted to Aboriginal and Torres Strait Islander peoples, however about 90 per cent of clients receiving the service are Aboriginal and Torres Strait Islanders

b) The total budget provided to the Office for Aboriginal and Torres Strait Islander Health (OATSIH) for 2002-03 was $253.6 million and for 2001-02 was $224 million. This was administered through Central Office in Canberra as well as through the network of State and Territory Offices.

c) During 2001-02, the OATSIH budget was spent on:
   i) Administration costs, including corporate service provision $22 million;
   ii) The Aboriginal Community Controlled Health Sector $164 million;
   iii) Universities and TAFEs $3 million
   iv) Consultancies $3 million

Additional funding of around $32million was provided to State/Territory Governments and other Government bodies for provision of health services, infrastructure development and vaccine funding (some of this is passed on to community controlled services in the form of funds or service provision) and a small amount to other organisations. These include the private sector for provision of services to Indigenous Australians (eg COMGAS) and committee members for meeting expenses.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-108

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: CONTRACT WITH AUSTRALIAN HEARING SERVICES

Hansard Page: CA 189

Senators Crossin & McLucas asked:

(a) What is the training component of the $380,000 contract for services with Australian Hearing Services?
(b) What is the breakdown of the total funding?

Answer:

(a) The training component of the $380,000 contract for services with Australian Hearing Services provides for training up to the value of $286,776.00.
(b) The breakdown of the total funding for the Training and Equipment Program is as follows:

| **Components** | **Maximum Value** |
|---|---|
| Calibration and Maintenance Packages | $69,916 |
| Training | $286,776 |
| Consolidation Training | $9,950 |
| Co-facilitator | $10,364 |
| Accreditation | $3,392 |
| **Total** | **$380,398** |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-109

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE USE PROGRAM – RESIDENTIAL TREATMENT AND REHABILITATION PROGRAMS

Hansard Pages: CA 189, 190, 192

Senator Crossin asked:

a) Can you advise me how much money was budgeted on residential treatment programs for drug and alcohol rehabilitation?
b) Of the $21.024 million allocated for the substance use budget would you know if half of that money is on residential rehab programs or more than a third and how is this broken down by state/territory?
c) How many places or programs in the residential treatment programs do you actually fund?
d) In funding by places I wanted to know how many are filled?
e) Would you have an idea of how many programs are requested and how many you then cannot fund because your bucket of money is not enough to meet the demand?
f) What are the different types of residential treatment programs funded?
g) Does someone living in a remote community, for example, get travel assistance to go to a major centre where these residential programs are?

Answer:

a) Information on Commonwealth funded stand-alone residential substance use services

   Of the 43 stand alone Commonwealth funded Aboriginal and Torres Strait Islander substance use services, 31 provide residential treatment and rehabilitation programs for substance use.

   Funding for residential services is budgeted at $10.409 million for the 2002/03 financial year.

b) The $10.409 million allocated to residential rehabilitation services is approximately half of the total funds allocated to the OATSIH Substance Use Program nationally. Other funding may be spent on rehabilitation/treatment activity that is not necessarily delivered by a residential service. The State/Territory breakdown is as follows:

| **State/Territory** | **Residential Funding** |
|---|---|
| New South Wales | $2,045,610 |
| Northern Territory | $2,292,323 |
| Queensland | $2,892,169 |
| South Australia | $1,921,556 |
| Victoria | $513,237 |
| Western Australia | $745,021 |
| | |
| **Total** | **$10,409,916** |

c) OATSIH provides funding to deliver substance use services on a holistic basis. OATSIH does not fund on a per place basis. In 1999-2000 there were 667 beds/residential places in Commonwealth funded stand-alone Aboriginal and Torres Strait Islander residential substance use services. This includes beds and residential places from all sources of funding including Aboriginal Hostels Ltd.

d) These numbers are not available. OATSIH does not collect data on the number of places filled or vacant within the funded substance use residential services.

e) Currently, there are no formal applications being considered in Central Office for new residential programs. When applications are received they would be considered in conjunction with other potential funders including:

- Alcohol Education and Rehabilitation Foundation
- State/Territory governments
- Aboriginal Hostels Ltd.

f) The organisations funded under the OATSIH Substance Use Program have adopted (and in some cases developed) varying approaches and models to address changing trends in their communities. Models range from tertiary level care and interventions (promoting abstinence based on the '12 step' approach) to secondary and primary level interventions and services (sobering up shelters, detoxification and promotion/prevention strategies).

g) Our understanding is Aboriginal Community Controlled Health Services do not routinely provide travel assistance for clients who are in need of residential rehabilitation when that client is in a remote community and the residential rehabilitation program is not locally available. In practice, we understand every effort is made by the referring and receiving services to arrange travel via a variety of means.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-110

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: QUALITY IMPROVEMENT COUNCIL – STANDARDS FOR ALCOHOL, TOBACCO AND OTHER DRUGS IN SUBSTANCE USE SERVICES IN SOUTH AUSTRALIA

Hansard Page: CA 191

Senator Crossin asked:

At what stage is the ADAC Quality Improvement Project?

Answer:

The Quality Assurance pilot being conducted through the Aboriginal Drug and Alcohol Council of South Australia is in its fourth and final year and is due to finish in October 2003. The pilot project will be externally evaluated in the latter half of this year with recommendations relating to the effectiveness of QA processes in their application to Substance Use services

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-113

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: EYE HEALTH REVIEW

Hansard Page: CA 195

Senator Crossin asked:

Please provide a copy of the Terms of Reference of the Review of the National Aboriginal and Torres Strait Islander Eye Health Program.

Answer:

The objectives of the Review are to:
- describe and report on the nature and extent of implementation of the Eye Health Program including an examination of the effectiveness and efficiency of key elements of the program;
- identify options for strengthening the Eye Health Program's integration with primary health care services for Aboriginal and Torres Strait Islander people;
- identify how the program articulates with mainstream eye health programs and services (such as the Visiting Optometrists Scheme), and how such relationships could be strengthened;
- provide recommendations on how to improve Indigenous Australians access to primary eye health care and specialists;
- identify and report on models of service delivery where there have been demonstrated improvements in access to services, eye health care and in eye health outcomes; and
- identify mechanisms to improve data available to report on program progress.

In line with the objectives of the Review, the Consultant is required to identify and analyse the following questions with regard to trachoma:

Identify which areas included in the Review are endemic trachoma areas, and in those areas:
- identify which of these undertake regular screening activity;
- provide a comprehensive description of the screening methods, complete with data definitions and intensity;
- identify reports/results available in recent years; and
- provide a qualitative assessment from appropriate staff as to the severity of the problem.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-114

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM

Hansard Page: CA 196

Senator Crossin asked:

(a) In relation to question E02-087 (Supplementary Budget Estimate Hearings – Nov 02) which was a table you provided to me in relation to expenditure on the Primary Health Care Access Program, could you provide me with an update on the figures in that table?

(b) Has there been any delay in the roll out of these funds and where are we at with that?

Answer:

(a)

| | **2002-03 PHCAP expenditure to week of 24 February 2003** | **Budgeted amounts 2002-03** | **Agreed estimated population levels – (Indigenous Australians)** |
|---|---|---|---|
| **Northern Territory wide** | $203,861 | $329,000 | |
| Tiwi | $1,302,879 | $4,348,156 (1) (2) | 2,000 |
| Katherine West | $2,268,885 | $2,950,726 | 3,060 |
| Sunrise | $220,000 | $517,200 | 2,275 |
| Anmatjerra | $17,875 | $1,190,252 (1) (2) (3) | 1,305 |
| Eastern Arrente-Alyawarre | $19,490 | $1,020,658 (1) (2) (3) | 877 |
| Northern Barkly | $60,100 | $394,525 (1) (2) (3) | 821 |
| Warlpiri | $870,578 | $1,735,378 (1) (2) (3) | 1,612 |
| Laritja Pintubi | $45,654 | $947,974 (1) (2) (3) | 1,298 |
| **South Australia** | | | |
| Northern Metro | $125,000 | $1,230,200(1) (2) | 4,115 |
| Wakefield | $0 | $0 (3) | 758 |
| Hills Mallee Southern | $0 | $0 (3) | 1,390 |
| Port Augusta sub-region | $255,000 | $255,000 (2) (3) | 3,068 |
| Riverland | $72,350 | $72,350 (2) (3) | 623 |

| PHCAP site | 2002-03 PHCAP expenditure to week of 24 February 2003 | Budgeted amounts 2002-03 | Agreed estimated population levels – (Indigenous Australians) |
|---|---|---|---|
| **Queensland** | | | |
| Queensland wide | $13,000 | $13,000 | |
| Atherton/Croydon | $0 | $36,000 (3) | 4,180 |
| Central Highlands | $0 | $36,000 (3) | 1,688 |
| Inland/Mt Isa | $0 | $36,000 (3) | 4,315 |
| Near South West | $0 | $36,000 (3) | 1,210 |
| Torres | $0 | $120,000 (3) | 6,850 |
| **Capacity Building sites QLD** | | | |
| Gulf | $0 | $15,000 (3) | 3,796 |
| Cook | $0 | $530,000 (2) (3) | 3,240 |
| **NSW** | | | |
| Wilcannia | $214,113 | $696,450 | 1,000 |
| **Western Australia** | | | |
| Perth/Bunbury | $1,755,687 | $2,920,761 | 1990 |
| **TOTAL** | **$7,444,472** | **$19,430,630** | **51,471** |

(1) includes capital allocations for works currently underway.
(2) funds available 2002-03 as allocated to date.

(3) final budget will depend on the outcome of the planning processes currently underway or to commence shortly.

(b) There has been some delay in the roll out of these funds for the capital works projects in the Central Australian sites due to the difficulties in identifying the most appropriate auspicing body/fund holders. A tender process is nearing completion and it is expected that these projects will reach practical completion/handover by January 2004.

Negotiations with the Northern Territory Government in regards to the Program Management of the Tiwi Health Clinic capital works, which have led to some delays in the roll out of funds, have now been finalised and the clinic is expected to be completed by the end of this year.

A Funding Agreement is currently being finalised for capacity building activity in the Cook region in Queensland and funding is expected to be released shortly.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-049

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: NATIONAL INDIGENOUS AUSTRALIAN'S SEXUAL HEALTH STRATEGY

Written Question on Notice

Senator Harradine asked:

I refer to the "National Indigenous Australian's Sexual Health Strategy"

(a) How much funding was provided to the Peer Education Program of Sexual Health and Family Planning ACT (SHFPACT) from the Strategy?
(b) Please provide a copy of the peer education manual and comic book, developed as part of the Peer Education Program.
(c) How many people have received education from this program?
(d) How many people have completed this program and been employed by SHFPACT?

Answer:

(a) The total Commonwealth funding from the National Indigenous Australians' Sexual Health Strategy for the Peer Education Program of Sexual Health and Family Planning ACT (SHFPACT) was $60,000 for the 2001/2002 and $63,000 for the 2002/2003 financial years. The Commonwealth Government and the ACT Government's Department of Health and Community Care are providing a combined total of $162,000 for the life of the Peer Education program. The ACT Government is managing the contract with SHFPACT.

(b) Provided.

(c) Over the life of the Peer Education Program, 24 people have participated, with another 14 starting the course in early June.

(d) Over the life of the Peer Education Program, six people have completed the residential program, with another six to complete shortly.

Five people have been employed by SHFPACT either as outreach workers or within the organisation as a receptionist. All twelve people completing the residential course will be employed as casual peer or outreach workers, with some to be based with other organisations. The final number employed with SHFPACT is not yet known.

Commonwealth Department of
Health and Ageing

Health Industry and Investment Division
GPO Box 9848, Canberra ACT 2601
Telephone: (02) 6289 9417 Fax: (02) 6289 9444

Senator Susan Knowles
Chair
Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2600

Dear Senator Knowles

**Budget Estimates Hearings 2002-2003, 5 & 6 June 2002**

I am writing to clarify information this Department provided to a question taken on notice (SEQON E02-169) at the Estimates Hearing on 5 June 2002.

Senator Evans asked the following question:

"How much money has been spent on advertising for private health insurance in the year 2001-02?"

The Department stated in its response:

"In 2001, $9,630,893.41 was spent on production and placement of advertisements related to private health insurance: $8,727,460.89 was spent in financial year 2000-01; $903,432.52 was spent in financial year 2001-02."

The response was accurate based on the information available at that time. However, in light of subsequent and final reconciliation of expenditure, the response should now be amended as follows (changes marked):

"In 2001, $9,630,893.41 *(exclusive of GST)* was spent on production and placement of advertisements related to private health insurance: *$8,596,962.67* was spent in financial year 2000-01; *$1,033,930.74* was spent in financial year 2001-02."

The two other questions answered in response to SEQON E02-169 do not require amendment.

Yours sincerely

Louise Morauta
First Assistant Secretary
Acute Care Division
January 2003

# Medibank Private

## Managing Director

Senator Susan Knowles
Chairman
Senate Community Affairs Legislation Committee
Parliament House

CANBERRA ACT 2600

25 March 2003

Dear Senator Knowles,

**Medibank Private Limited – Commercial Arrangements with ICSGlobal Limited**

I am writing to clarify responses provided by Medibank Private Limited to questions from Senator Evans during the Additional Estimates hearings of the Senate Community Affairs Legislation Committee on Thursday 13 February 2003 (Hansard pages CA 178 to 184, CA 196 and CA 200 to 205).

Senator Evans asked a series of questions regarding Medibank Private's commercial arrangements with ICSGlobal Limited, a publicly listed company that has developed an information technology platform for the private health industry know as "THELMA". In particular, Senator Evans asked questions regarding:

- The number of industry players signed up with ICSGlobal;
- The nature of Medibank Private's commercial relationship with ICSGlobal;
- The date upon which the commercial arrangements were finalised and the ASX notified;
- The issuing and pricing of options issued by ICSGlobal to unrelated parties; and
- Process of notification in relation to the ICSGlobal arrangement;

I would like to clarify my answers to the above questions by providing the following supplementary information.

**Industry Players Connected to "THELMA"**

Medibank Private has been endeavouring to replace manual claims processing with on-line solutions for 3 years. ICS Global is one of several methodologies used. Medibank Private began dialogue with ICSGlobal in mid 2000. At present, there are approximately 90 private and public hospitals, and day surgeries, billing agencies which represent over 1,000 specialists, alongside 15 health funds and 14 corporate health plans connected to the THELMA platform operated by ICS Global.

**Medibank Private's Commercial Relationship with ICSGlobal**

Both private health funds and private hospitals commit to use THELMA by executing a User Agreement with ICS Global. This agreement sets out the terms and conditions (including associated costs) for the use of THELMA. On the evening of 27 August 2002, Medibank Private and ICSGlobal entered into a three year non-exclusive User Agreement at a cost to Medibank Private of approximately $40,000 per annum (covering IT costs and licence fees) plus potential transaction fees.

Whilst the following information is sensitive, it is been disclosed to provide greater transparency. In addition to the User Agreement, the parties agreed a commercial arrangement to allow Medibank Private the right (but not the obligation) to participate in the potential future direct corporate value accruing to ICSGlobal as a result of executing the User Agreement. This commercial structure would also provide Medibank Private leverage to deal with ICSGlobal as a potential key third party provider into the future. Previous experience in the ancillary sector has proven that such leverage is important should the adopted system become a widely used industry platform.

To that end the commercial arrangement consisted of two further documents, a Subscription Agreement and Option Agreement.

Subject to the approval of the Medibank Private Board and Federal Government, the Subscription Agreement grants Medibank Private the right to progressively call for up to 5% of the issued share capital in ICSGlobal (as at 28 August 2002) at no cost over a period of up to two years. The right to call for the shares is linked to the extent to which Medibank Private uses THELMA. Put simply, the more Medibank Private uses THELMA the more of the 5% share capital can be called for. The precise terms relating to the use of THELMA (triggering the right to call for the 5% of shares) are commercial in confidence.

Subject to the approval of the Medibank Private Board and Federal Government, the Option Agreement grants Medibank Private the right to exercise an option to acquire 14.9% of the issued share capital in ICSGlobal (as at 28 August 2002) at an exercise price (or "strike price") of $0.40 per share for a period of four years. These option rights were issued at no cost, as distinct from the $0.40 strike price if the options are exercised. The Option Agreement represents rights in addition to the 5% of shares that may be unlocked pursuant to the Subscription Agreement.

The $0.40 option exercise price was agreed as one aspect of the broader commercial agreement. Furthermore, the $0.40 exercise price reflected an appropriate commercial discount to the share price at the time Medibank Private commenced its formal evaluation and consideration of the THELMA platform.

Both the Subscription Agreement and the User Agreement represent rights for Medibank Private, not obligations.

**Date of Commercial Arrangements and ASX Notification**

On 12 August 2002, ICSGlobal informed the ASX that it had reached an in-principle agreement with Medibank Private to execute a User Agreement and "equity option agreement". (Refer attached ICSGlobal's ASX announcement dated 12 August 2002).

On the evening of 27 August 2002, ICSGlobal and Medibank Private entered into the User Agreement, Subscription Agreement and Option Agreement. On the morning of 28 August 2002, ICS Global notified the ASX of the commercial arrangements (Refer attached ASX announcement dated 28 August 2002).

It should be noted that the Option Agreement was conditional upon ICSGlobal shareholders' approval. The required approval was obtained at a company Extraordinary General Meeting on 18 October 2002.

The required ASX notification Appendix 3B relating to the issue of the options to Medibank Private was lodged with the ASX on 22 October 2002.

**Issuing and Pricing of Options by ICS Global to Unrelated Parties**

Having been prompted by Senator Evans' question, Medibank Private has reviewed the Australian Stock Exchange record and can confirm that on 22 October 2002, ICSGlobal issued 1,600,000 options to unnamed individuals in "recognition of advisory services provided by external parties over the last twelve months…" (see attached ASX notification dated 22 October 2002). This transaction is totally unrelated to the commercial arrangements negotiated between ICSGlobal and Medibank Private.

It is further noted that these options have an exercise price of $0.20. Presumably ICSGlobal and the option recipients agreed this exercise price on the basis and extent of ICSGlobal share price movements "over the last twelve months" and the "advisory services provided". However, this is a commercial and confidential issue for ICSGlobal of which Medibank Private has no further details other than those contained in the 22 October 2002 ASX notification. Accordingly, Medibank Private is not in a position to provide further meaningful comment on this matter.

**Process of Notification**

The User Agreement represented a relatively small financial commitment ($40,000 per annum plus transaction fees) and constituted normal business for Medibank Private. Furthermore, on the basis that both the Subscription Agreement and the Option Agreement represented a right and not an obligation, any exercise of which would be subject to the prior approval of the Medibank Private Board and the Federal Government, direct Ministerial approval was not required for these arrangements.

It should be noted that these decisions are consistent with Medibank Private's obligations under section 40 of the Commonwealth Authorities and Companies Act 1997. Section 40 requires Medibank Private to notify the responsible Minister only if the arrangement is significant, or involves the formation of a company or acquisition of a significant shareholding or business.

Both Shareholder GBE Unit representatives and Ministerial Advisers were kept fully informed of the commercial negotiations from 11 August 2002 onwards.

Normal disclosure through Shareholder GBE representatives in reporting and general briefings with Ministerial Advisers has continued with regard to ICSGlobal and other e-commerce initiatives.

Medibank Private continues to update Government on the status of the ICSGlobal relationship through Monthly and Quarterly Shareholder Reports.

Yours sincerely

**George Savvides**
**Managing Director**
*Medibank Private Limited*

Attachments enclosed

ATTI. E03-129

**ICSGLOBAL LIMITED (ICS)** **ASX RELEASE** **12 AUGUST 2002**

# THELMA Seeks to Sign Medibank Private

THELMA and Australia's largest health fund, Medibank Private Limited, have reached an in-principle agreement to sign a THELMA User Agreement and equity option agreement presented to Medibank Private by ICSGlobal Limited.

The exercise of the equity option agreement will require and is subject to the approval of shareholders of ICSGlobal Limited and Medibank Private's Board.

THELMA (Transactional Health Exchange Linking Multiple Applications) is a health industry electronic clearing house. THELMA generates both subscription and transaction revenue through replacing existing manual, paper-based health administration processes with intelligent technologies that allow B2B transactions over the Internet.

The User Agreement will initially focus on Private Hospital eligibility checks. It might be expanded to include other electronic processing services subject to the further agreement of both parties.

Formal documentation of the agreement is currently being finalised and a detailed announcement will be made once this is done.

ICSGlobal Limited is an e-health company whose core business is the ownership and operation of THELMA.

**Released by:** ICSGlobal Limited. For further information or media inquiries:

Tim Murray
Managing Director
ICSGlobal Limited
Ph: (02) 9247 2111

ATT2 E03-129

**ICSGLOBAL LIMITED (ICS)** **ASX RELEASE** **28 AUGUST 2002**

# Medibank Private sign for THELMA and take option in ICSGlobal

Medibank Private Limited ("Medibank"), Australia's largest private health fund, has signed a three year User Agreement for THELMA.

THELMA (Transactional Health Exchange Linking Multiple Applications) is a health industry electronic clearing house. THELMA generates both subscription and transaction revenue through replacing existing manual, paper-based health administration processes with intelligent technologies that allow B2B transactions over the Internet.

The User Agreement relates to a range of transactions with Private Hospital eligibility checks being the initial focus. Subject to the success of the eligibility checks initiative, both parties will then work together to implement other electronic claims, which may include hospital, medical, pathology, radiology and ancillary claims (which covers services such as dental, physiotherapy and optometry).

As part of the transaction and subject to Medibank Board approval, approximately 3 million ordinary shares in ICSGlobal Limited ("ICS"), representing approximately 5% of ICS issued capital of approximately 60.5 million shares, may be progressively issued to Medibank or a Medibank subsidiary. Upon signing of the User Agreement, Medibank or its subsidiary will be entitled to be issued approximately 750,000 of the 3 million ordinary shares in ICS. Further tranches of the 3 million shares will be issued if transaction volume thresholds are achieved within the next 2 years.

In addition to the issue of 3 million shares noted above, Medibank or its subsidiary will also be issued with approximately 9 million options over ordinary shares in ICS, representing approximately 14.9% of existing ICS issued capital, at an exercise price of forty cents per share and having a 4 year option period. The issue of the options is subject to the approval of shareholders of ICS. The exercise of the options will require Medibank Board approval.

ICS Managing Director Tim Murray said he expects that having Medibank connected to THELMA will trigger a domino effect of THELMA take up.

"The health industry has been waiting to see what the major players are doing in terms of e-health connectivity. With Medibank involvement, now virtually all public and private hospitals have a compelling business case for connecting to THELMA. As the hospitals connect, the other health funds also have a compelling business case for connecting to THELMA, to connect into this electronic hospital grid through a single interface" said Mr Murray.

Medibank Private is the sixth private health fund to sign up to THELMA, and takes THELMA's national health fund market share to approximately 40%.

ICS is an e-health company whose core business is the ownership and operation of THELMA.

**Released by:** ICSGlobal Limited. For further information or media inquiries:

Tim Murray, Managing Director, ICSGlobal Limited, Ph: (02) 9247 2111

Australian Stock Exchange

ICS000078


## Appendix 3B - Recognition of advisory services

**Document date:** Tue 22 Oct 2002 **Published:** Tue 22 Oct 2002 16:38:08
**Document No:** 278258 **Document part:** A
**Market Flag:** N
**Classification:** Appendix 3B

ICSGLOBAL LIMITED 2002-10-22 ASX-SIGNAL-G

HOMEX - Sydney

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APPENDIX 3B
NEW ISSUE ANNOUNCEMENT

APPLICATION FOR QUOTATION OF ADDITIONAL SECURITIES AND AGREEMENT

Information or documents not available now must be given to ASX as soon as available. Information and documents given to ASX become ASX's property and may be made public.

Introduced 1/7/96. Origin Appendix 5. Amended 1/7/98, 1/9/99, 1/7/2000.

Name of Entity
ICSGLOBAL Limited

ABN
72 073 695 584

We (the entity) give ASX the following information.

PART 1 - ALL ISSUES
You must complete the relevant sections (attach sheets if there is not enough space).

| | | |
|---|---|---|
| 1. | Class of securities issued or to be issued | Options over Ordinary Shares |
| 2. | Number of securities issued or to be issued (if known) or maximum number which may be issued | Maximum which may be issued: 1,600,000 |
| 3. | Principal terms of the securities (eg, if options, exercise price and expiry date; if partly paid securities, the amount outstanding and due dates for payment; if convertible securities, the conversion price and dates for conversion) | Exercise price $0.20<br>Expiry Date: 22/10/2004<br>Options: 1,600,000 |
| 4. | Do the securities rank equally in all respects from the date of allotment with an existing class of quoted securities<br><br>If the additional securities do not rank equally, please state:<br>* the date from which they do<br>* the extent to which they participate for the next dividend, (in the case of a trust, distribution) or interest payment<br>* the extent to which they do not rank equally, other than in relation to the next dividend, distribution or interest payment | Yes |
| 5. | Issue price or consideration | Nil |

| | | |
|---|---|---|
| 6. Purpose of the issue (if issued as consideration for the acquisition of assets, clearly identify those assets) | Recognition of advisory services provided by external parties over the last twelve months and the achievement of specific performance milestones. | |
| 7. Dates of entering securities into uncertified holdings or despatch of certificates | 22/10/2002 | |
| | NUMBER | CLASS |
| 8. Number and class of all securities quoted on ASX (including the securities in clause 2 if applicable) | 60,887,079 | Ordinary Shares |
| | NUMBER | CLASS |
| 9. Number and class of all securities not quoted on ASX (including the securities in clause 2 if applicable) | 2,530,670 | Employee Options |
| | 525,000 | Employee Options with performance hurdles attached |
| | 3,055,670 | Total Employee Options |
| | 9,027,724 | Medibank Private Limited Options |
| | 1,600,000 | Other Options |
| 10. Dividend policy (in the case of a trust, distribution policy) on the increased capital (interests) | Not applicable | |

PART 2 - BONUS ISSUE OR PRO RATA ISSUE

Items 11 to 33 are Not Applicable

PART 3 - QUOTATION OF SECURITIES

You need only complete this section if you are applying for quotation of securities

Items 34 to 37 are Not Applicable

Entities that have Ticked Box 34 (b)

Items 38 to 42 are Not Applicable

ALL ENTITIES

Fees

43. Payment method (tick one)

Cheque attached

Electronic payment made
Note: Payment may be made electronically if Appendix 3B is given to ASX electronically at the same time.

Periodic payment as agreed with the home branch has been arranged
Note: Arrangements can be made for employee incentive schemes that involve frequent issues of securities.

QUOTATION AGREEMENT

1. Quotation of our additional securities is in ASX's absolute discretion. ASX may quote the securities on any conditions it decides.

2. We warrant the following to ASX.

* The issue of the securities to be quoted complies with the complies with the law and is not for an illegal purpose.

* There is no reason why those securities should not be granted quotation.

* An offer of the securities for sale within 12 months after their issue will not require disclosure under section 707(3) or section 1012C(6) of the Corporations Act.

* Section 724 or section 1016E of the Corporations Act does not apply to any applications received by us in relation to any securities to be quoted and that no-one has any right to

return any securities to be quoted under sections 737, 738 or 1016F of the Corporations Act at the time that we request that the securities be quoted.

* We warrant that if confirmation is required under section 1017F of the Corporations Act in relation to the securities to be quoted, it has been provided at the time that we request that the securities be quoted.

* If we are a trust, we warrant that no person has the right to return the securities to be quoted under section 1019B of the Corporations Act at the time that we request that the securities be quoted.

3. We will indemnify ASX to the fullest extent permitted by law in respect of any claim, action or expense arising from or connected with any breach of the warranties in this agreement.

4. We give ASX the information and documents required by this form. If any information or document not available now, will give it to ASX before quotation of the securities begins. We acknowledge that ASX is relying on the information and documents. We warrant that they are (will be) true and complete.

T Walther
COMPANY SECRETARY
22/10/2002

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# Australian Health Insurance Association Ltd

(ABN 33 008 621 994 - A COMPANY LIMITED BY GUARANTEE - INCORPORATED IN THE A.C.T.)

PRESIDENT:
Mr Terry Smith MBE RPD ED

CHIEF EXECUTIVE
Mr Russell Schneider

NATIONAL SECRETARIAT:
4 Campion Street
Deakin ACT 2600

Telephone: (02) 6285 2977
Facsimile: (02) 6285 2966
Email: admin@ahia.org.au

7 February 2003

Senator the Hon Kay Patterson
Minister for Health & Ageing
Suite MG48
Parliament House
CANBERRA ACT 2600

**"LIFESTYLE" ANCILLARY BENEFITS**

Dear Minister

I refer to the question of certain "lifestyle" ancillary benefits provided by some health funds which have been the subject of recent adverse publicity and criticism, particularly from the Federal Opposition.

As you would be aware most Lifestyle benefits provide rebates for Diabetes and Asthma Education programs, Quit Smoking courses, Weight Management, Women's Health, Stress Management and similar programs. Other items, such as sporting clothing and equipment, in fact represent a miniscule component of total outlays. They have generally been provided with a view both to encouraging fitness and also on-going membership by young, healthier members who make few other claims but whose membership helps health funds meet the claims costs of less healthy members.

Over the last year a number of funds have withdrawn these benefits, and others have been reviewing their programs.

I am now writing to advise you that the AHIA Executive has considered this question and asked me to advise you that, in its view, ancillary benefits should not extend to cover items normally purchased for the purpose of sport, recreation or entertainment. This would exclude, among other items, sporting equipment, sporting clothing, musical equipment and items used for outdoor recreation. It would also exclude gym membership other than that required as part of a health management program.

Obviously it would be unfair to withdraw this coverage from existing policy contracts for which members may have an expectation of claims in the future without reasonable notice. We would therefore propose to have them phased out on the basis of non-renewal when existing contracts expire.

Although AHIA has formed this conclusion, the Executive is very conscious of the fact that it should take no action in respect of either recommending members withdraw such benefits or endorse a code which would have the same effect without the approval of the ACCC. I will be discussing our most appropriate course of action with the ACCC over the next few days. As any action may require authorisation processes, I would hope the Government - and the Federal Opposition - would support any such move without qualification.

LOCATION:

Finally it should be noted that withdrawal of these benefits, though involving very small costs to health funds overall, may disappoint some members. I would hope that both the Government and the Opposition parties would support this move and do all in their power to encourage those people to appreciate the benefits of health fund coverage and maintain their membership despite the withdrawal of this benefit. I would also hope that funds will be allowed flexibility on how they communicate these changes to members/policy-holders.

Yours sincerely

**RUSSELL SCHNEIDER**
**CHIEF EXECUTIVE OFFICER**

** TOTAL PAGE.003 **

LOCATION:

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-127

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH INSURANCE – MEDIBANK PRIVATE

Hansard Page: CA 181

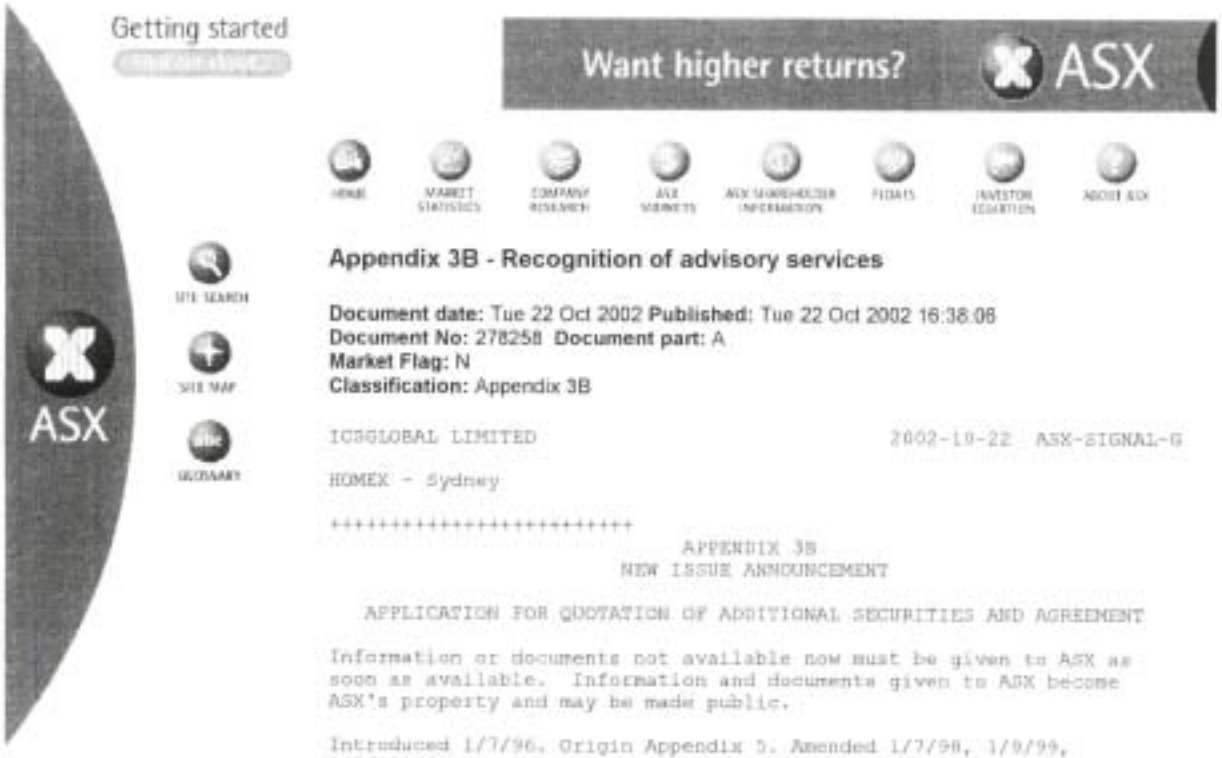
Senator Evans asked:

I understand that by my information is that, on the same day that you exercised your option and notified your option for three million shares at 40c with an option for nine million at 40c, 1.6 million shares were also offered to other parties at 20c each. It would seem that you were paying twice the rate that they were. I am interested in why that was.

Answer:

Medibank Private has reviewed the Australian Stock Exchange record and can confirm that on 22 October 2002, ICS Global issued 1,600,000 options to unnamed individuals in "recognition of advisory services provided by external parties over the last twelve months…" (see attached ASX notification dated 22 October 2002). This transaction is totally unrelated to the commercial arrangements negotiated between ICSGlobal and Medibank Private.

It is further noted that these options have an exercise price of $0.20. Presumably ICS Global and the option recipients agreed this exercise price on the basis and extent of ICSGlobal share price movements "over the last twelve months" and the "advisory services provided". However, this is a commercial and confidential issue for ICS Global of which Medibank Private has no further details other than those contained in the 22 October 2002 ASX notification. Accordingly, Medibank Private is not in a position to provide further meaningful comment on this matter.




## Appendix 3B - Recognition of advisory services

**Document date:** Tue 22 Oct 2002 **Published:** Tue 22 Oct 2002 16:38:08
**Document No:** 278258 **Document part:** A
**Market Flag:** N
**Classification:** Appendix 3B

ICSGLOBAL LIMITED 2002-10-22 ASX-SIGNAL-G

HOMEX - Sydney

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APPENDIX 3B
NEW ISSUE ANNOUNCEMENT

APPLICATION FOR QUOTATION OF ADDITIONAL SECURITIES AND AGREEMENT

Information or documents not available now must be given to ASX as soon as available. Information and documents given to ASX become ASX's property and may be made public.

Introduced 1/7/96. Origin Appendix 5. Amended 1/7/98, 1/9/99, 1/7/2000.

Name of Entity
ICSGLOBAL Limited

ABN
72 073 695 584

We (the entity) give ASX the following information.

PART 1 - ALL ISSUES
You must complete the relevant sections (attach sheets if there is not enough space).

| | | |
|---|---|---|
| 1. | Class of securities issued or to be issued | Options over Ordinary Shares |
| 2. | Number of securities issued or to be issued (if known) or maximum number which may be issued | Maximum which may be issued: 1,600,000 |
| 3. | Principal terms of the securities (eg, if options, exercise price and expiry date; if partly paid securities, the amount outstanding and due dates for payment; if convertible securities, the conversion price and dates for conversion) | Exercise price $0.20<br>Expiry Date: 22/10/2004<br>Options: 1,600,000 |
| 4. | Do the securities rank equally in all respects from the date of allotment with an existing class of quoted securities<br><br>If the additional securities do not rank equally, please state:<br>* the date from which they do<br>* the extent to which they participate for the next dividend, (in the case of a trust, distribution) or interest payment<br>* the extent to which they do not rank equally, other than in relation to the next dividend, distribution or interest payment | Yes |
| 5. | Issue price or consideration | Nil |

| | | |
|---|---|---|
| 6. Purpose of the issue (if issued as consideration for the acquisition of assets, clearly identify those assets) | Recognition of advisory services provided by external parties over the last twelve months and the achievement of specific performance milestones. | |
| 7. Dates of entering securities into uncertified holdings or despatch of certificates | 22/10/2002 | |

| | NUMBER | CLASS |
|---|---|---|
| 8. Number and class of all securities quoted on ASX (including the securities in clause 2 if applicable) | 60,887,079 | Ordinary Shares |

| | NUMBER | CLASS |
|---|---|---|
| 9. Number and class of all securities not quoted on ASX (including the securities in clause 2 if applicable) | 2,530,670 | Employee Options |
| | 525,000 | Employee Options with performance hurdles attached |
| | 3,055,670 | Total Employee Options |
| | 9,027,724 | Medibank Private Limited Options |
| | 1,600,000 | Other Options |

| | |
|---|---|
| 10. Dividend policy (in the case of a trust, distribution policy) on the increased capital (interests) | Not applicable |

PART 2 - BONUS ISSUE OR PRO RATA ISSUE

Items 11 to 33 are Not Applicable

PART 3 - QUOTATION OF SECURITIES

You need only complete this section if you are applying for quotation of securities

Items 34 to 37 are Not Applicable

Entities that have Ticked Box 34 (b)

Items 38 to 42 are Not Applicable

ALL ENTITIES

Fees

43. Payment method (tick one)

Cheque attached

Electronic payment made
Note: Payment may be made electronically if Appendix 3B is given to ASX electronically at the same time.

Periodic payment as agreed with the home branch has been arranged
Note: Arrangements can be made for employee incentive schemes that involve frequent issues of securities.

QUOTATION AGREEMENT

1. Quotation of our additional securities is in ASX's absolute discretion. ASX may quote the securities on any conditions it decides.

2. We warrant the following to ASX.

* The issue of the securities to be quoted complies with the complies with the law and is not for an illegal purpose.

* There is no reason why those securities should not be granted quotation.

* An offer of the securities for sale within 12 months after their issue will not require disclosure under section 707(3) or section 1012C(6) of the Corporations Act.

* Section 724 or section 1016E of the Corporations Act does not apply to any applications received by us in relation to any securities to be quoted and that no-one has any right to

return any securities to be quoted under sections 737, 738 or 1016F of the Corporations Act at the time that we request that the securities be quoted.

* We warrant that if confirmation is required under section 1017F of the Corporations Act in relation to the securities to be quoted, it has been provided at the time that we request that the securities be quoted.

* If we are a trust, we warrant that no person has the right to return the securities to be quoted under section 1019B of the Corporations Act at the time that we request that the securities be quoted.

3. We will indemnify ASX to the fullest extent permitted by law in respect of any claim, action or expense arising from or connected with any breach of the warranties in this agreement.

4. We give ASX the information and documents required by this form. If any information or document not available now, will give it to ASX before quotation of the securities begins. We acknowledge that ASX is relying on the information and documents. We warrant that they are (will be) true and complete.

T Walther
COMPANY SECRETARY
22/10/2002

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-129

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH INSURANCE – MEDIBANK PRIVATE

Hansard Page: CA 204

Senator Evans asked:

Why wasn't that noted in the ASX until October? Do you understand that?

Answer:

On 12 August 2002, ICS Global informed the ASX that it had reached an in-principle agreement with Medibank Private to execute a User Agreement and "equity option agreement". (Refer attached ICS Global's ASX announcement dated 12 August 2002).

On the evening of 27 August 2002, ICS Global and Medibank Private entered into the User Agreement, Subscription Agreement and Option Agreement. On the morning of 28 August 2002, ICS Global notified the ASX of the commercial arrangements (Refer attached ASX announcement dated 28 August 2002).

It should be noted that the Option Agreement was conditional upon ICS Global shareholders' approval. The required approval was obtained at a company Extraordinary General Meeting on 18 October 2002.

The required ASX notification Appendix 3B relating to the issue of the options to Medibank Private was lodged with the ASX on 22 October 2002.

ATTI. E03-129

**ICSGLOBAL LIMITED (ICS)** **ASX RELEASE** **12 AUGUST 2002**

# THELMA Seeks to Sign Medibank Private

THELMA and Australia's largest health fund, Medibank Private Limited, have reached an in-principle agreement to sign a THELMA User Agreement and equity option agreement presented to Medibank Private by ICSGlobal Limited.

The exercise of the equity option agreement will require and is subject to the approval of shareholders of ICSGlobal Limited and Medibank Private's Board.

THELMA (Transactional Health Exchange Linking Multiple Applications) is a health industry electronic clearing house. THELMA generates both subscription and transaction revenue through replacing existing manual, paper-based health administration processes with intelligent technologies that allow B2B transactions over the Internet.

The User Agreement will initially focus on Private Hospital eligibility checks. It might be expanded to include other electronic processing services subject to the further agreement of both parties.

Formal documentation of the agreement is currently being finalised and a detailed announcement will be made once this is done.

ICSGlobal Limited is an e-health company whose core business is the ownership and operation of THELMA.

**Released by:** ICSGlobal Limited. For further information or media inquiries:

Tim Murray
Managing Director
ICSGlobal Limited
Ph: (02) 9247 2111

ATT2 E03-129

**ICSGLOBAL LIMITED (ICS)** **ASX RELEASE** **28 AUGUST 2002**

# Medibank Private sign for THELMA and take option in ICSGlobal

Medibank Private Limited ("Medibank"), Australia's largest private health fund, has signed a three year User Agreement for THELMA.

THELMA (Transactional Health Exchange Linking Multiple Applications) is a health industry electronic clearing house. THELMA generates both subscription and transaction revenue through replacing existing manual, paper-based health administration processes with intelligent technologies that allow B2B transactions over the Internet.

The User Agreement relates to a range of transactions with Private Hospital eligibility checks being the initial focus. Subject to the success of the eligibility checks initiative, both parties will then work together to implement other electronic claims, which may include hospital, medical, pathology, radiology and ancillary claims (which covers services such as dental, physiotherapy and optometry).

As part of the transaction and subject to Medibank Board approval, approximately 3 million ordinary shares in ICSGlobal Limited ("ICS"), representing approximately 5% of ICS issued capital of approximately 60.5 million shares, may be progressively issued to Medibank or a Medibank subsidiary. Upon signing of the User Agreement, Medibank or its subsidiary will be entitled to be issued approximately 750,000 of the 3 million ordinary shares in ICS. Further tranches of the 3 million shares will be issued if transaction volume thresholds are achieved within the next 2 years.

In addition to the issue of 3 million shares noted above, Medibank or its subsidiary will also be issued with approximately 9 million options over ordinary shares in ICS, representing approximately 14.9% of existing ICS issued capital, at an exercise price of forty cents per share and having a 4 year option period. The issue of the options is subject to the approval of shareholders of ICS. The exercise of the options will require Medibank Board approval.

ICS Managing Director Tim Murray said he expects that having Medibank connected to THELMA will trigger a domino effect of THELMA take up.

"The health industry has been waiting to see what the major players are doing in terms of e-health connectivity. With Medibank involvement, now virtually all public and private hospitals have a compelling business case for connecting to THELMA. As the hospitals connect, the other health funds also have a compelling business case for connecting to THELMA, to connect into this electronic hospital grid through a single interface" said Mr Murray.

Medibank Private is the sixth private health fund to sign up to THELMA, and takes THELMA's national health fund market share to approximately 40%.

ICS is an e-health company whose core business is the ownership and operation of THELMA.

**Released by:** ICSGlobal Limited. For further information or media inquiries:

Tim Murray, Managing Director, ICSGlobal Limited, Ph: (02) 9247 2111

Australian Stock Exchange

ICS000078

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-130

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH INSURANCE – MEDIBANK PRIVATE

Hansard Page: CA 204

Senator Evans asked:

When did you sign off the deal with ICSGlobal?

Answer:

Refer to answer to E03-129.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-128

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH INSURANCE – MEDIBANK PRIVATE

Hansard Page: CA 182

Senator Evans asked:

Just so that I am clear; the first option is for three million shares at 40cents each but the remainder of the
option or leveraging-up as you call it, is also at the rate of 40c.

Answer:

Subject to the approval of the Medibank Private Board and Federal Government, the Subscription Agreement grants Medibank Private the right to progressively call for up to 5% of the issued share capital in ICS Global (as at 28 August 2002) at no cost over a period of up to two years. The right to call for the shares is linked to the extent to which Medibank Private uses THELMA. Put simply, the more Medibank Private uses THELMA the more of the 5% share capital can be called for. The precise terms relating to the use of THELMA (triggering the right to call for the 5% of shares) are commercial in confidence.

Subject to the approval of the Medibank Private Board and Federal Government, the Option Agreement grants Medibank Private the right to exercise an option to acquire 14.9% of the issued share capital in ICS Global (as at 28 August 2002) at an exercise price (or "strike price") of $0.40 per share for a period of four years. These option rights were issued at no cost, as distinct from the $0.40 strike price if the options are exercised. The Option Agreement represents rights in addition to the 5% of shares that may be unlocked pursuant to the Subscription Agreement.

The $0.40 option exercise price was agreed as one aspect of the broader commercial agreement. Furthermore, the $0.40 exercise price reflected an appropriate commercial discount to the share price at the time Medibank Private commenced its formal evaluation and consideration of the THELMA platform.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-133

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH

Topic: ADDITIONAL BOOKING CHARGES

Hansard Page: CA 185

Senator McLucas asked:

Do you have records of people complaining about booking fees, especially from specialists?

Answer:

In 2002, the Private Health Insurance Ombudsman (PHIO) received 5 complaints about the imposition of additional fees by specialists. These were variously described as booking fees, administration fees or simply additional charges to cover increased insurance premiums. Only one of the complaints was identified as involving a doctor participating in a no-gap scheme. In that case, following PHIO inquiries, the additional fee was not enforced/collected. These complaints generally involved the late notification of the additional fee (after the procedure had been booked). PHIO is less likely to receive complaints about such additional fees where they have been disclosed as part of the doctor's initial fee notification.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-122

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: HEALTH FUND PRODUCT CHANGES

Hansard Page: CA199 and written question on notice

Senator McLucas asked:

(a) Can I have a list of those.
(b) Could you update that list if there are any other funds that have applied to change their discounting arrangements?

Answer:

(a) The following health funds have notified the Department about changes to their products since 21 November 2002. Their product changes are listed:

| Fund | Description of change | Date of effect |
|---|---|---|
| NRMA Health Pty Ltd | • Extras Super Plus table became an addition to hospital table only.<br>• Changes to ancillary benefits limits. | 1 January 2003 |
| Australian Health Management Group | • Excess applied to day only facility, public hospital, or for a day only stay in a private hospital.<br>• Various changes and reductions in ancillary benefits and limits.<br>• Sports equipment benefit removed. | 1 January 2003 |
| CBHS Friendly Society Ltd | • Increased excess on all hospital tables<br>• Reduced per service benefits for optical appliances. Annual benefit limit unchanged.<br>• Range of lifestyle benefits reduced.<br>• New definition of "Preventive Health Service" added for benefits for approved preventive screenings and tests.<br>• Limit on benefits per member for some ancillary services<br>• Reduction in dental benefits. | 1 January 2003 |

| | | |
|---|---|---|
| Navy Health | • Caps benefits per service for a variety of ancillary services.<br>• Maximum benefit per family per benefit year for some services. | 1 February 2003 |
| Australian Unity Health Ltd | • Increases to some ancillary benefits<br>• Inclusion of some new ancillary benefits<br>• Closure of tables to new members | 1 February 2003 |
| IOR Australia Pty Ltd | • Benefits for some ancillary services based on percentage of charge recognised by IOR, instead of percentage of fee charged | 1 February 2003 |
| IOR Australia Pty Ltd | • Closure of some products to new members.<br>• Introduction of new products | 17 February 2003 |

The following health funds have also notified the Department of changes to their products. However, as the proposed changes have not yet come into effect, details are commercial-in-confidence:

BUPA Australia Health Pty Limited
Medibank Private Limited
Mildura District Hospital Fund Limited
HBF Health Funds Inc
Queensland Country Health Limited
Grand United Health Fund Limited
Health Insurance Fund of Western Australia
Western Districts Health Fund Limited
Cessnock District Health Benefits Fund Limited
Phoenix Health Fund Limited
Teachers' Federation Health
United Ancient Order of Druids Friendly Society Limited
Medical Benefits Fund of Australia
IOOF Health Services Limited
Australian Unity Health Limited
Manchester Unity Australia Limited
GMHBA Limited
Australian Health Management Group
ACA Health Benefits Fund
Health Care Insurance Limited
Health-Partners
Defence Health
Federation Health
Transport Friendly Society
IOR Australia Pty Ltd
NRMA Health Pty Ltd

(b) No other health funds have applied to the Department to change their discounting arrangements since the response to Question E02–104 of 9 December 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-196

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: HEALTH FUND PRODUCT CHANGES

Hansard Page: CA199 & written question on notice

Senator McLucas asked:

(a) Since 1996, has the Department of Health and Ageing made any payments to the Australian Health Insurance Association by way of any consultancy, fee for service or other arrangement?

(b) If so, what was the cost and the purpose of the arrangement?

Answer:

(a) Yes.

(b) The following payments have been made to the AHIA:

| **PAYMENT** | |
|---|---|
| Sitting Fees for Consumer Focus Collaboration Meeting, 2001-02 | $297.00 |
| Sitting Fees for Consumer Focus Collaboration Meeting, 2000-01 | $286.00 |
| Sitting Fees for Consumer Focus Collaboration Meeting, 1999-00 | $250.00 |
| Reimbursement of Airfare: Casemix Conference, 1996-97 | $308.00 |
| Refund of overpayment for Medicare Diskette 1996-97 | $411.05 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-134

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH

Topic: COMPLAINTS TO THE PRIVATE HEALTH INSURANCE OMBUDSMAN

Hansard Page: CA 199

Senator McLucas asked:

(a) Could you provide on notice the number of complaints that the office has received for every financial year since inception of the office?

(b) Is it possible to find out how many of those complaints relate to ancillary claims?

Answer:

(a) **1995/6 (**first year of Private Health Insurance Complaints Commissioner)**:** 244 complaints (3 month period)
**1996/7:** 1211 complaints
**1997/8:** 1966 complaints
**1998/9** (first full year of Private Health Insurance Ombudsman)**:** 1812 complaints;
**1999/2000:**1875 complaints
**2000/1:** 3357 complaints
**2001/2:** 3182 complaints

(b) No. The PHIO complaint database contains records of complaints by health fund and by issue (e.g. service problem, premium increase, oral information, benefit amount, etc). Staff members do not necessarily record whether a complaint is related to "ancillary cover". However, see also the response to question E03-135.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-135

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH

Topic: COMPLAINTS TO THE PRIVATE HEALTH INSURANCE OMBUDSMAN

Hansard Page: CA 199

Senator McLucas asked:

Could you provide us with a complete list of complaints relating to ancillary claims since November 2001, the date received, the type of ancillary, the date of resolution and the outcome of the complaint – including any recommendation as to the value of compensation to the claimant.

Answer:

For the period specified, PHIO estimates there were approximately 560 complaints in which a specific problem related to ancillary benefits. This compared to a total of 4005 complaint issues registered for that period. To provide the information requested would involve an individual check all complaints received. I am sorry that I cannot justify the use of limited PHIO resources for that task. However, a check of a sample (50 complaints) of ancillary benefits complaints was undertaken.

From the sample of 50 ancillary cover related complaints, the type of cover/benefit complained about were:
Dental 22 (44%); Optical 6 (12%); Physiotherapy 5 (10%), All ancillary benefits 4 (8%), Other ancillary benefits 13 (26%).

In the sample the "Other ancillary benefits" included:
(Breast Prosthesis (after mastectomy) 2; CPAP Machine 2, Sporting Goods 2, Orthotics 2, Psychology 2, Sleep Apnoea Device 1, Podiatry 1, Breathing Appliance 1.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-200

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH FUND PREMIUM INCREASES

Hansard Page: CA199

Senator McLucas asked:

Since last Estimates:
(a) Have any funds approached the Health Department about changes to their products?
(b) Could we have a list of those funds and the products which have been changed?

Answer:

(a-b) Please refer to the response to Question E03-122.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-03, 13 February 2003

Question: E03-201

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH FUND PREMIUM INCREASES

Hansard Page: CA199 and written question on notice

Senator McLucas asked:

Since last Estimates:
(a) Have any funds advised the Department that they were withdrawn (sic) discounting arrangements?
(b) If so, could we please have a list of those funds, a description of the discounts that were withdrawn, the relevant premium and the number of people who were affected?

Answer:

(a-b) Please refer to the response to Question E03 – 122.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-131

OUTCOME 9: HEALTH INVESTMENT

Topic: BOND UNIVERSITY AND UNIVERSITY OF NOTRE DAME

Hansard Page: CA 175

Senator Allison asked:

When were the most recent discussions held where their proposals were brought to you?

Answer:

After checking my diary I can confirm that I had a meeting on 3 December 2002, with Mr Peter Castleton from the Bond University to discuss the University's Medical School proposal.

I also had a meeting on 8 August 2002, with Mr Peter Tannick from the University of Notre Dame.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-132

OUTCOME 9: HEALTH INVESTMENT

Topic: NET EFFECT ON NURSE TRAINING AND MIDWIVES - SHORTAGES

Hansard Page: CA 178

Senator McLucas asked:

But the net effect on nurse training and midwives is that we will potentially exacerbate the shortage we already have.

Ms Jane Halton – Another point that has also been made is that because we do not administer education, this is not something we can directly comment on. I think we have said that at the last couple of estimates.

Mr Robert Wells – I think we had information from the universities relating to the last estimates period. I will have to take this on notice whether there is any update or change to that.

Answer:

On 6 June 2002, the attached information was provided directly to Senator Allison in relation to the impact of insurance cover on the provision of clinical placements for medical and nursing students. The situation for nursing students remains unchanged since that time, with the exception that one institution, Flinders University, which was previously experiencing difficulty in obtaining cover for midwifery placements, now has cover.

THE IMPACT OF INSURANCE COVER ON THE PROVISION OF CLINICAL PLACEMENTS FOR MEDICAL AND NURSING STUDENTS

The Department contacted the Committee of Deans of Australian Medical Schools, the Deans of Medicine at the University of New South Wales, the University of Western Australia, the University of Adelaide and Flinders University and the Deans of Nursing at the University of Sydney, University of Adelaide, Charles Sturt University, Flinders University and the University of South Australia to ascertain the current situation concerning the impact of insurance cover on the provision of clinical placements for medical and nursing students

We have been advised that for medical students the following applies:

- All Australian universities have insurance cover for medical students undertaking clinical placements. This is arranged through individual universities and covers public liability, professional indemnity and personal accident policies.
- No university has made a significant recent change to their medical student insurance cover.
- No medical students have been prevented from proceeding with a clinical placement due to a lack of insurance cover. However, all universities indicated concerns regarding current medical insurance issues.

We have been advised that for nursing students the following applies:

- The universities canvassed do have insurance cover for nursing students covering public liability and professional indemnity. Some also have personal accident and/or medical malpractice insurance, excluding students undertaking some midwifery courses.
- Insurance is arranged through individual universities.
- No nursing students, excluding students undertaking midwifery courses, have been excluded from clinical placements due to insurance cover.

The University of Sydney was unable to offer clinical placements to maternal and obstetric nursing students this year due to their inability to purchase medical malpractice insurance. Flinders University has advised that insurance companies have refused to cover midwifery students. However, the Department of Human Services in South Australia has put in place an interim measure to cover midwifery students in public hospitals until December 2002 to allow students to complete the current course.

Some universities canvassed (University of Sydney and University of Adelaide) advised that postgraduate students are not affected, as they are Registered Nurses and their insurance is provided by their employer.

| | |
|---|---|
| Division: | HIID |
| Cleared by: | Robert Wells |
| Phone: | (02) 6289 7404 |
| Date: | 6 June 2002 |
| Outcome: | 9 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-001

OUTCOME 9: HEALTH INVESTMENT

Topic: NEW EXPERT COMMITTEE

Written Question on Notice

Senator Collins asked:

(a) Please outline the NHMRC's process in establishing the new Expert Committee on Human Embryo and Stem Cell Research?
(b) Please provide me with the names and background details of each of the members of this new committee.
(c) Please provide a list of organisations that were approached and asked to provide nominations for the new committee.
(d) Were any of the organisations likely to be critical of human embryo research?
(e) How has a balanced approach to the ethical issues related to embryo research been achieved?
(f) Will this new expert committee overtake the Australian Health Ethics Committee as the primary source of ethics advice for human research ethics committees? If so, why?
(g) Please explain the role this new expert committee will take?
(h) Why was its establishment not canvassed during the debate into the Research Involving Human Embryos Act?

Answer:

(a) At its 143rd Meeting on 9 August 2002, the NHMRC agreed to establish an advisory committee to provide authoritative advice to Council, researchers, ethics committees and other interested parties during the period until the Licensing Committee is established. This advice would relate to technical aspects of human embryos and stem cell research and related issues. On 18/19 September 2002, the NHMRC's Research Committee agreed to accept this task from Council.

(b) The committee has not yet been established.

(c) The following bodies were asked to provide nominations for appointment:
- Australian Health Ethics Committee of NHMRC
- The Royal Australian and New Zealand College of Obstetricians and Gynaecologists
- The Royal Australasian College of Surgeons
- The Royal Australian College of General Practitioners
- The Medical Faculties of Australian Universities
- Consumers' Health Forum

- ACCESS ((Australia's National Infertility Network) an independent, non profit, consumer based organisation)
- Fertility Society of Australia (FSA)
- Therapeutic Goods Administration.
- Australasian Bioethics Association
- The Australian Association of Medical Research Institutes [AAMRI]
- The Authorities in each of the 3 States responsible for administering the infertility treatment legislation,
    - Infertility Treatment Authority of Victoria
    - Reproductive Technology Council of SA
    - WA Reproductive Technology Council
- Human Genetics Society Of Australasia

(d) The NHMRC did not canvas whether the organisations listed in c) have a position on embryo research.

The organisations were contacted to provide nominations covering the broad range of technical, regulatory, medical, bioethical and consumer expertise required for such an expert committee.

(e) The committee has not yet been established.

(f) No.

(g) The Committee has not yet been established and the Research Committee is still considering the membership and terms of reference.

(h) The establishment of the expert committee was not germane to the debate on the Bills before Parliament.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-002

OUTCOME 9: HEALTH INVESTMENT

Topic: IMPLEMENTATION OF RESEARCH INVOLVING HUMAN EMBRYOS ACT

Written Question on Notice

Senator Collins asked:

(a) What are the key priorities and timeframe for establishing the NHMRC Licensing Committee? Are you on schedule with this project?
(b) What are the key priorities and timeframe for the finalisation of the new NHMRC Ethical Guidelines on Assisted Reproductive Technology? Are you on schedule with this project?
(c) What are the key priorities and timeframe for the finalisation of new regulations under the Research Involving Human Embryos Act? Are you on schedule with this project?

Answer:

(a) The process for the appointment of the Licensing Committee is set out in sections 13 to 17 of the *Research Involving Human Embryos Act 2002*. The NHMRC Secretariat is assisting the Minister to finalise nominations. It is anticipated that the committee will be appointed and have had the opportunity to consider licence applications before the offence provisions of the *Research Involving Human Embryos Act 2002* on 19 June 2003.

(b) Public consultation on the revised draft guidelines commenced on 12 February 2003 and concluded on 28 March 2003. Following consideration of the submissions received, it is anticipated that the revised guidelines will be issued in final form by the NHMRC in mid-2003.

(c) The Research Involving Human Embryos Regulations were gazetted on 27 February 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-026

OUTCOME 9: HEALTH INVESTMENT

Topic: HUMAN RESEARCH ETHICS COMMITTEES

Written Question on Notice

Senator Harradine asked:

(a) What steps are being taken to clarify the role of Human Research Ethics Committees under the Research Involving Human Embryos Act and to make their activities more transparent and accountable?
(b) Please provide details of the process the Department follows to monitor HRECs.
(c) How many Human Research Ethics Committees are there in Australia?
(d) Would you please provide me with a table which details for each of the last three calendar years, by each state and territory and in total:
    (i) The number of human research ethics committees
    (ii) The number of HRECs that are attached to commercial organisations
    (iii) The number of HRECs that are attached to university organisations
    (iv) The number of HRECs that are attached to other research organisations
    (v) The number of HRECs that don't fit these other categories.
(e) Would you please provide me with a table which details for each of the last three calendar years, by each state or territory and in total:
    (i) The number of applications to HRECs
    (ii) The number of application to HRECs approved on first application
    (iii) The number of applications approved after modifications
    (iv) The number of applications rejected

Answer:

(a) The NHMRC has recently produced a document specifically designed to assist human research ethics committees (HRECs) to understand their role under the *Research Involving Human Embryos Act 2002* in considering proposals involving the use of excess ART embryos, and to assist them to fulfil this role. This document has been supplied to all HRECs that have notified their existence to AHEC.

(b) In June each year the Australian Health Ethics Committee (AHEC) secretariat sends an annual report form to all human research ethics committees (HRECs) notified to AHEC. Through this annual report form AHEC collects information from HRECs for the previous financial year on their operations and compliance with specific NHMRC guidelines for the previous financial year. HREC compliance is assessed against requirements set out in the:

- *National Statement on Ethical Conduct in Research Involving Humans* (National Statement)*;*
- *Guidelines under Section 95 of the Privacy Act 1988* (s95 guidelines)*;* and
- *Guidelines approved under Section 95A of the Privacy Act 1988* (s95A guidelines).

The chair of the HREC and the head of the institution responsible for establishing and maintaining the HREC are both required to sign a declaration confirming that the information provided in the annual report form is correct and that the HREC operates in accordance with the National Statement.

Following receipt of this information, AHEC prepares a report to Council's Research Committee regarding HREC compliance with NHMRC guidelines and a report to the Federal Privacy Commissioner on HREC compliance with the s95 and s95A guidelines.

(c) There are currently 217 human research ethics committees notified to AHEC.

(d) AHEC collects information from HRECs about their operations and compliance with NHMRC guidelines on a financial year basis. The table at attachment 1 provides details available for the 1999-2000, 2000-2001 and 2001-2002 reporting periods. The annual report form requests that HRECs identify whether they are attached to one of four types of institution, namely: hospitals; universities; government bodies or other bodies. This information is not available on a State and Territory basis. Please note that this table only reports on HRECs that have notified their existence to AHEC.

(e) AHEC collects information from HRECs about their operations and compliance with NHMRC guidelines on a financial year basis. The table at attachment 1 provides details available for the 1999-2000, 2000-2001 and 2001-2002 reporting periods. The AHEC secretariat collects information on the number of proposals approved each financial year and the number of proposals rejected each financial year. This information is not available on a State and Territory basis. The AHEC secretariat does not collect information on the number of applications to HRECs that are approved on first application, nor the number of applications approved after modifications. Please note that this table only reports on HRECs that have notified their existence to AHEC.

**Attachment 1**

**The number of Human Research Ethics Committees and information on the type of institutions to which they are attached**

| Reporting period | Total number of HRECs | No. attached to universities | No. attached to hospitals | No. attached to government bodies | No. attached to other bodies |
|---|---|---|---|---|---|
| 1999-2000 | 212 | 47 | 90 | 37 | 37 |
| 2000-2001 | 199 | 49 | 81 | 32 | 34 |
| 2001-2002 | 214 | 47 | 86 | 34 | 41 |

**The number of research proposals approved and rejected by HRECs**

| Reporting period | Total number approved | Total number rejected |
|---|---|---|
| 1999-2000 | 15, 264 | 242 |
| 2000-2001 | 14, 726 | 398 |
| 2001-2002 | 16, 715 | 258 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-027

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC PROJECT GRANTS

Written Question on Notice

Senator Harradine asked:

Please provide me with a table showing the number of applications, the number of grants awarded and the total dollar value of NHMRC project grant awards to institutions by each state or territory for each year over the past five calendar years.

Answer:

See Attachment A for tables as requested.

Note: Ministerial approval for grants commencing 2001 and prior were done on a year by year basis. Ministerial approval for grants commencing 2002 onward is given for the total (accrued) budget.

**Funding by Institution for Project Grants Commencing in 1999**

This table shows the total first year budget awarded to NHMRC Project Grants commencing in 1999.

| State | Administration Institution | #of Applications | #Successful | Funding Total |
|---|---|---|---|---|
| NSW | Centenary Institute of Cancer Medicine and Cell Biology | 4 | 1 | 64,689 |
| NSW | Charles Sturt University | 2 | | |
| NSW | Children's Medical Research Institute | 5 | 2 | 165,242 |
| NSW | Concord Repatriation General Hospital | 1 | | |
| NSW | Heart Research Institute | 3 | 1 | 59,319 |
| NSW | Macquarie University | 5 | 1 | 87,345 |
| NSW | NSW Cancer Council | 1 | 1 | 192,767 |
| NSW | NSW Breast Council | 1 | | |
| NSW | Northern Rivers Area Health Sevice | 1 | | |
| NSW | Prince Henry & Wales Hospital | 2 | | |
| NSW | Royal North Shore Hospital | 6 | | |
| NSW | Royal Prince Alfred Hospital | 15 | 5 | 393,742 |
| NSW | Southern Cross University | 2 | | |
| NSW | The New Children's Hospital | 13 | 3 | 458,461 |
| NSW | University of New England | 3 | 1 | 42,608 |
| NSW | University of New South Wales | 109 | 15 | 1,556,502 |
| NSW | University of Newcastle | 46 | 13 | 1,067,848 |
| NSW | University of Sydney | 158 | 43 | 3,713,647 |
| NSW | University of Technology Sydney | 9 | 1 | 13,025 |
| NSW | University of Western Sydney, Nepean | 2 | 1 | 35,611 |
| NSW | University of Wollongong | 9 | 1 | 93,586 |
| NSW | Victor Chang Cardiac Research Institute | 7 | 4 | 402,230 |
| NSW | Westmead Hospital | 10 | 1 | 46,800 |
| **NSW STATE TOTAL** | | **414** | **94** | **8,393,422** |
| VIC | Alfred Hospital | 1 | | |
| VIC | Anti - Cancer Council of Victoria | 5 | | |
| VIC | Austin and Repatriation Medical Centre | 2 | | |
| VIC | Austin Hospital Medical Research Foundation | 3 | | |
| VIC | Austin Research Institute | 3 | 3 | |

| | | | | |
|---|---|---|---|---|
| | | | | 647,871 |
| VIC | Centre for Development and Innovation | 1 | | |
| VIC | CSIRO Division of Wool Technology | 1 | | |
| VIC | Deakin University | 20 | 2 | 242,749 |
| VIC | Geelong Hospital | 1 | | |
| VIC | Heart Research Centre | 1 | | |
| VIC | Kingston Centre | 1 | | |
| VIC | La Trobe University | 21 | 7 | 701,933 |
| VIC | Ludwig Institute for Cancer Research | 6 | 2 | 113,965 |
| VIC | Macfarlane Burnet Centre for Medical Research | 6 | | |
| VIC | Mental Health Research Institute of Victoria | 4 | | |
| VIC | Monash University | 143 | 26 | 2,504,839 |
| VIC | Mutation Research Centre | 2 | 1 | 61,199 |
| VIC | National Ageing Research Institute | 3 | | |
| VIC | National Vision Research Institute of Australia | 2 | 1 | 54,880 |
| VIC | Prince Henry's Institute of Medical Research | 7 | 4 | 409,521 |
| VIC | Royal Childrens Hospital Res Rd | 15 | 2 | 173,460 |
| VIC | Royal Melbourne Hospital Research Foundation | 12 | 3 | 186,842 |
| VIC | Royal Melbourne Institute of Technology | 14 | 1 | 95,727 |
| VIC | Royal Women's Hospital, Melbourne | 5 | | |
| VIC | St. Vincent's Hospital Melbourne | 14 | 2 | 124,600 |
| VIC | St. Vincent's Institute of Medical Research | 4 | 2 | 174,657 |
| VIC | Swinburne University | 1 | | |
| VIC | Turning Point Alcohol and Drug Centre | 3 | 1 | 25,439 |
| VIC | University of Ballarat | 1 | | |
| VIC | University of Melbourne | 182 | 53 | 4,981,434 |
| VIC | Victoria University of Technology | 1 | | |
| **VIC STATE TOTAL** | | **485** | **110** | **10,499,116** |
| QLD | Griffith University | 19 | 2 | 110,332 |
| QLD | James Cook University | 10 | 1 | 67,787 |
| QLD | Mater Misericordiae Hospital / Mater Medical Research Institute | 5 | 1 | 61,992 |
| QLD | Prince Alexandra Hospital | 1 | 1 | 49,800 |
| QLD | Prince Charles Hospital | 2 | | |

| | | | | |
|---|---|---|---|---|
| QLD | Queensland Institute of Medical Research | 2 | | |
| QLD | Queensland University of Technology | 26 | 2 | 172,240 |
| QLD | Royal Brisbane Hospital | 3 | | |
| QLD | Royal Brisbane Hospital Research Foundation | 1 | 1 | 58,412 |
| QLD | Royal Children's Hospital, Brisbane | 7 | 1 | 62,049 |
| QLD | Royal Womens Hospital | 1 | | |
| QLD | University of Queensland | 144 | 43 | 3,747,183 |
| QLD | University of Southern Queensland | 4 | | |
| QLD | Wesley Research Institute | 2 | | |
| **QLD STATE TOTAL** | | **227** | **52** | **4,329,795** |
| SA | Flinders University of South Australia | 51 | 11 | 724,645 |
| SA | Institute of Medical and Veterinary Science | 4 | 3 | 277,862 |
| SA | Repatriation General Hospital, Daw Park | 1 | | |
| SA | Royal Adelaide Hospital | 2 | | |
| SA | The Queen Elizabeth Hospital | 1 | 1 | 56,969 |
| SA | University of Adelaide | 97 | 30 | 2,288,432 |
| SA | University of South Australia | 7 | 2 | 97,755 |
| **SA STATE TOTAL** | | **163** | **47** | **3,445,663** |
| WA | Curtin University of Technology | 10 | | |
| WA | Edith Cowan University | 6 | | |
| WA | Murdoch University | 4 | 1 | 53,004 |
| WA | Princess Margaret Hospital | 1 | | |
| WA | Royal Perth Hospital | 5 | | |
| WA | Sir Charles Gairdner Hospital Perth | 3 | | |
| WA | University of Western Australia | 124 | 35 | 3,080,586 |
| **WA STATE TOTAL** | | **153** | **36** | **3,133,590** |
| TAS | University of Tasmania | 22 | 7 | 443,104 |
| **TAS STATE TOTAL** | | **22** | **7** | **443,104** |
| ACT | Australian National University | 19 | 4 | 297,471 |
| ACT | The Canberra Hospital | 4 | | |
| ACT | The University of Canberra | 1 | | |
| **ACT STATE TOTAL** | | **24** | **4** | **297,471** |

| | | | | |
|---|---|---|---|---|
| NT | Menzies School of Health Research | 17 | 4 | 380,506 |
| **NT STATE TOTAL** | | **17** | **4** | **380,506** |
| **NATIONAL TOTAL** | | **1505** | **354** | **30,922,667** |

**Funding by Institution for Project Grants Commencing in 2000**

This table shows the total first year budget awarded to NHMRC Project Grants commencing in 2000.

| State | Administration Institution | #of Applications | #Successful | Funding Total |
|---|---|---|---|---|
| NSW | Australian Red Cross Blood Service | 1 | 0 | 0 |
| NSW | NSW Cancer Council | 2 | 0 | 0 |
| NSW | Centenary Institute | 17 | 9 | 874,266 |
| NSW | Children's Medical Research Inst | 4 | 2 | 207,542 |
| NSW | Charles Sturt University | 1 | 0 | 0 |
| NSW | Concord Repatriation General Hosp. | 2 | 0 | 0 |
| NSW | Heart Research Institute | 5 | 4 | 258,978 |
| NSW | Institute of Dental Research | 6 | 0 | 0 |
| NSW | Macquarie University | 2 | 0 | 0 |
| NSW | Mater Misericordiae Hosp | 1 | 1 | 36,110 |
| NSW | Orange Base Hospital | 1 | 0 | 0 |
| NSW | The New Children's Hospital | 9 | 1 | 231,556 |
| NSW | Royal Flying Doctor Service NSW Section | 1 | 0 | 0 |
| NSW | Royal North Shore Hospital | 1 | 0 | 0 |
| NSW | Royal Prince Alfred Hospital | 10 | 2 | 154,280 |
| NSW | South Eastern Syd Area Hlth Serv. | 3 | 0 | 0 |
| NSW | South Western Syd Area Hlth Serv. | 1 | 0 | 0 |
| NSW | Southern Cross University | 1 | 0 | 0 |
| NSW | St. Vincent's Hospital | 0 | 0 | 0 |
| NSW | University of New England | 9 | 1 | 54,204 |
| NSW | University of Newcastle | 58 | 11 | 829,707 |
| NSW | University of N.S.W. | 152 | 33 | 2,638,452 |
| NSW | University of Sydney | 198 | 60 | 5,306,376 |
| NSW | University of Technology | 9 | 1 | 81,209 |
| NSW | University of Wollongong | 11 | 0 | 0 |
| NSW | University of Western Sydney Hawkesbury | 1 | 0 | 0 |
| NSW | University of Western Sydney Macarthur | 2 | 0 | 0 |
| NSW | Uni of Western Sydney, Nepean | 3 | 1 | 61,088 |
| NSW | Victor Chang Cardiac Res Instit | 7 | 5 | 628,825 |
| NSW | Westmead Hospital | 13 | 2 | 219,915 |
| **NSW STATE TOTAL** | | **531** | **133** | **11,582,508** |
| VIC | Anti-Cancer Council of Victoria | 5 | 3 | 336,702 |

| | | | | |
|---|---|---|---|---|
| VIC | Alfred Hospital | 3 | 0 | 0 |
| VIC | Austin Hospital Medical Research | 1 | 0 | 0 |
| VIC | Austin and Repatriation Medical Centre | 4 | 0 | 0 |
| VIC | Austin Research Institute | 2 | 0 | 0 |
| VIC | Australian Catholic University | 1 | 0 | 0 |
| VIC | Biomolecular Research Institute | 5 | 2 | 180,617 |
| VIC | Baker Medical Research Institute | 0 | 0 | 0 |
| VIC | Brain Research Institute | 3 | 1 | 98,567 |
| VIC | Centre for Eye Research Aust Ltd | 3 | 2 | 371,556 |
| VIC | Centre for Molecular Biology and Medicine | 2 | 0 | 0 |
| VIC | CSIRO Div of Textile & Fibre Technology | 1 | 1 | 96,525 |
| VIC | Deakin University | 19 | 2 | 118,730 |
| VIC | Fdn for Detection of Genetic Disorders | 5 | 0 | 0 |
| VIC | Geelong Hospital | 2 | 0 | 0 |
| VIC | La Trobe University | 23 | 2 | 229,713 |
| VIC | Ludwig Institute for Cancer Res | 9 | 1 | 53,816 |
| VIC | Macfarlane Burnet Centre | 7 | 1 | 62,501 |
| VIC | Mental Health Research Inst | 5 | 1 | 62,875 |
| VIC | Monash University | 152 | 51 | 4,759,069 |
| VIC | National Ageing Res Institute | 2 | 0 | 0 |
| VIC | National Stroke Foundation | 4 | 0 | 0 |
| VIC | National Vision Research Inst | 1 | 0 | 0 |
| VIC | Prince Henry's Institute | 5 | 3 | 207,263 |
| VIC | Royal Children's Hospital Res In | 19 | 1 | 41,384 |
| VIC | Royal Melbourne Hosp Res Fndn | 12 | 1 | 122,786 |
| VIC | Royal Melbourne Inst of Tech | 13 | 2 | 198,812 |
| VIC | Royal Women's Hospital, | 12 | 3 | 267,462 |
| VIC | St Vincent's Hospital | 11 | 3 | 248,114 |
| VIC | St. Vincent's Institute | 6 | 3 | 494,337 |
| VIC | Swinburne University | 3 | 1 | 42,062 |
| VIC | Turning Point Alcohol & Drug Cen | 3 | 1 | 122,335 |
| VIC | University of Ballarat | 2 | 0 | 0 |
| VIC | University of Melbourne | 175 | 54 | 6,076,356 |
| VIC | Victoria University of Tech | 2 | 1 | 61,764 |
| **VIC STATE TOTAL** | | **522** | **140** | **14,253,345** |

| | | | | |
|---|---|---|---|---|
| QLD | Griffith University | 17 | 4 | 311,537 |
| QLD | James Cook Uni of Nth Qld | 8 | 0 | 0 |
| QLD | Mater Misericordiae Hospitals | 5 | 2 | 184,139 |
| QLD | Prince Charles Hospital | 6 | 0 | 0 |
| QLD | Princess Alexandra Hospital | 2 | 0 | 0 |
| QLD | Queensland Cancer Fund | 1 | 1 | 81,812 |
| QLD | Queensland Institute of Medical | 0 | 0 | 0 |
| QLD | Queensland Uni of Technology | 15 | 2 | 288,273 |
| QLD | Royal Brisbane Hospital | 6 | 0 | 0 |
| QLD | Royal Bris Hosp Res Foundation | 5 | 0 | 0 |
| QLD | Royal Children's Hospital | 2 | 0 | 0 |
| QLD | University of Central Queensland | 1 | 0 | 0 |
| QLD | University of Southern Queensland | 2 | 0 | 0 |
| QLD | University of Queensland | 189 | 56 | 4,662,173 |
| QLD | Wesley Research Institute | 3 | 0 | 0 |

| | | | | |
|---|---|---|---|---|
| **QLD STATE TOTAL** | | **262** | **65** | **5,527,935** |

| | | | | |
|---|---|---|---|---|
| SA | University of Adelaide | 133 | 38 | 3,701,448 |
| SA | The Flinders University of SA | 65 | 18 | 1,885,416 |
| SA | Inst of Med and Vet Science | 5 | 1 | 59,758 |
| SA | Queen Elizabeth Hospital | 2 | 0 | 0 |
| SA | Royal Adelaide Hospital | 2 | 0 | 0 |
| SA | Repatriation General Hospital | 5 | 1 | 45,356 |
| SA | University of South Australia | 14 | 1 | 55,338 |
| SA | Women's and Children's Hospital | 4 | 0 | 0 |
| **SA STATE TOTAL** | | **230** | **59** | **5,747,317** |

| | | | | |
|---|---|---|---|---|
| WA | Curtin University of Technology | 18 | 7 | 657,030 |
| WA | Edith Cowan University | 5 | 0 | 0 |
| WA | Murdoch University | 6 | 1 | 75,179 |
| WA | Keogh Insitute for Medical Research | 2 | 1 | 141,672 |
| WA | Royal Perth Hospital | 2 | 0 | 0 |
| WA | Sir Charles Gairdner Hospital | 7 | 1 | 105,685 |
| WA | University of Western Australia | 113 | 27 | 2,940,738 |
| **WA STATE TOTAL** | | **153** | **37** | **3,920,305** |

| | | | | |
|---|---|---|---|---|
| TAS | University of Tasmania | 28 | 8 | 645,851 |
| **TAS STATE TOTAL** | | **28** | **8** | **645,851** |

| | | | | |
|---|---|---|---|---|
| ACT | Australian National University | 22 | 4 | 527,367 |
| ACT | University of Canberra | 1 | 0 | 0 |
| ACT | Canberra Hospital | 4 | 1 | 158,129 |
| **ACT STATE TOTAL** | | **27** | **5** | **685,495** |

| | | | | |
|---|---|---|---|---|
| NT | Menzies School of Health Res | 13 | 2 | 248,916 |
| NT | Northern Territory University | 3 | 0 | 0 |
| **NT STATE TOTAL** | | **16** | **2** | **248,916** |

| | | | | |
|---|---|---|---|---|
| **NATIONAL TOTAL** | | **1,769** | **449** | **42,611,671** |

**Funding by Institution for Project Grants Commencing in 2001**

This table shows the total first year budget awarded to NHMRC Project Grants commencing in 2001.

| State | Administration Institution | #of Applications | #Successful | Funding Total |
|---|---|---|---|---|
| NSW | Centenary Institute of Cancer Medicine and Cell Biology | 14 | 6 | 587,660 |
| NSW | Charles Sturt University | 3 | 0 | 0 |
| NSW | Children's Medical Research Institute | 7 | 3 | 456,615 |
| NSW | Concord Repatriation General Hospital | 1 | 0 | 0 |
| NSW | Garvan Institute of Medical Research | 3 | 1 | 155,665 |
| NSW | Heart Research Institute | 8 | 4 | 381,520 |
| NSW | Institute of Dental Research | 2 | 0 | 0 |

| | | | | |
|---|---|---|---|---|
| NSW | Macquarie University | 4 | 1 | 155,855 |
| NSW | NSW Cancer Council | 0 | 0 | 0 |
| NSW | Neuroscience Institute of Schizophrenia and Allied Disorders | 2 | 0 | 0 |
| NSW | Newcastle Mater Misericordiae Hospital | 1 | 0 | 0 |
| NSW | New England Area Health Service | 1 | 0 | 0 |
| NSW | Royal North Shore Hospital | 2 | 0 | 0 |
| NSW | Royal Prince Alfred Hospital | 14 | 5 | 386,330 |
| NSW | South Eastern Sydney Area Health Service | 4 | 0 | 0 |
| NSW | Southern Cross University | 4 | 0 | 0 |
| NSW | The New Children's Hospital | 14 | 1 | 65,285 |
| NSW | University of New England | 6 | 0 | 0 |
| NSW | University of New South Wales | 133 | 25 | 2,405,442 |
| NSW | University of Newcastle | 50 | 9 | 1,084,647 |
| NSW | University of Sydney | 210 | 59 | 6,143,621 |
| NSW | University of Technology Sydney | 9 | 0 | 0 |
| NSW | University of Western Sydney, Macarthur | 5 | 0 | 0 |
| NSW | University of Western Sydney, Nepean | 1 | 0 | 0 |
| NSW | University of Wollongong | 18 | 3 | 336,045 |
| NSW | Victor Chang Cardiac Research Institute | 7 | 6 | 662,350 |
| NSW | Westmead Hospital | 8 | 3 | 235,760 |
| **NSW STATE TOTAL** | | **531** | **126** | **13,056,795** |

| | | | | |
|---|---|---|---|---|
| VIC | Alfred Hospital | 2 | 1 | 70,285 |
| VIC | Anti - Cancer Council of Victoria | 5 | 0 | 0 |
| VIC | Austin and Repatriation Medical Centre | 2 | 0 | 0 |
| VIC | Austin Hospital Medical Research Foundation | 3 | 0 | 0 |
| VIC | Austin Research Institute | 5 | 0 | 0 |
| VIC | Baker Medical Research Institute | 4 | 2 | 210,950 |
| VIC | Biomolecular Research Institute | 3 | 0 | 0 |
| VIC | Brain Research Institute | 5 | 1 | 95,855 |
| VIC | Brotherhood of St Laurence | 1 | 0 | 0 |
| VIC | Centre for Eye Research Australia Ltd | 2 | 0 | 0 |
| VIC | Centre for Molecular Biology and Medicine | 3 | 0 | 0 |
| VIC | CSIRO Division of Textile and Fibre Technology | 0 | 0 | 0 |
| VIC | Deakin University | 18 | 1 | 107,785 |
| VIC | Geelong Hospital | 1 | 0 | 0 |
| VIC | Howard Florey Institute | 0 | 0 | 0 |
| VIC | La Trobe University | 34 | 5 | 396,330 |
| VIC | Ludwig Institute for Cancer Research | 17 | 10 | 773,325 |
| VIC | Macfarlane Burnet Centre for Medical Research | 7 | 1 | 70,285 |
| VIC | Mental Health Research Institute of Victoria | 7 | 1 | 100,000 |
| VIC | Monash University | 139 | 37 | 3,933,738 |

| | | | | |
|---|---|---|---|---|
| VIC | Murdoch Children's Research Institute | 47 | 2 | 133,190 |
| VIC | National Ageing Research Institute | 7 | 1 | 95,000 |
| VIC | National Stroke Foundation | 8 | 2 | 264,374 |
| VIC | National Vision Research Institute of Australia | 2 | 0 | 0 |
| VIC | Prince Henry's Institute of Medical Research | 9 | 5 | 547,660 |
| VIC | Royal Melbourne Hospital Research Foundation | 9 | 1 | 141,975 |
| VIC | Royal Melbourne Institute of Technology | 11 | 1 | 70,380 |
| VIC | Royal Women's Hospital, Melbourne | 7 | 2 | 195,570 |
| VIC | St. Vincent's Hospital Melbourne | 10 | 2 | 215,975 |
| VIC | St. Vincent's Institute of Medical Research | 13 | 7 | 833,800 |
| VIC | Swinburne University | 2 | 0 | 0 |
| VIC | Turning Point Alcohol and Drug Centre | 0 | 0 | 0 |
| VIC | University of Melbourne | 222 | 73 | 8,118,997 |
| VIC | Victoria University of Technology | 1 | 0 | 0 |
| VIC | Victorian Institute of Forensic Medicine | 1 | 0 | 0 |
| VIC | Walter and Eliza Hall Institute | 6 | 3 | 241,140 |
| **VIC STATE TOTAL** | | **613** | **158** | **16,616,614** |

| | | | | |
|---|---|---|---|---|
| QLD | Griffith University | 12 | 5 | 495,976 |
| QLD | James Cook University | 14 | 1 | 75,380 |
| QLD | Mater Misericordiae Hospital / Mater Medical Research Institute | 11 | 1 | 165,760 |
| QLD | Prince Charles Hospital | 5 | 0 | 0 |
| QLD | Queensland Cancer Fund | 0 | 0 | 0 |
| QLD | Queensland Institute of Medical Research | 6 | 4 | 334,640 |
| QLD | Queensland University of Technology | 20 | 2 | 155,950 |
| QLD | Royal Brisbane Hospital | 1 | 0 | 0 |
| QLD | Royal Brisbane Hospital Research Foundation | 5 | 2 | 180,475 |
| QLD | Royal Children's Hospital, Brisbane | 2 | 0 | 0 |
| QLD | University of Queensland | 177 | 50 | 5,138,922 |
| QLD | University of Southern Queensland | 2 | 0 | 0 |
| QLD | Wesley Research Institute | 2 | 0 | 0 |
| **QLD STATE TOTAL** | | **257** | **65** | **6,547,103** |

| | | | | |
|---|---|---|---|---|
| SA | Child Health Research Institute Inc. | 1 | 0 | 0 |
| SA | Flinders University of South Australia | 50 | 14 | 1,332,573 |
| SA | Institute of Medical and Veterinary Science | 11 | 4 | 406,615 |
| SA | Repatriation General Hospital, Daw Park | 5 | 2 | 275,570 |
| SA | Royal Adelaide Hospital | 2 | 1 | 75,380 |

| | | | | |
|---|---|---|---|---|
| SA | The Queen Elizabeth Hospital | 4 | 1 | 70,285 |
| SA | University of Adelaide | 124 | 30 | 2,852,685 |
| SA | University of South Australia | 10 | 1 | 65,190 |
| SA | Women's and Children's Hospital | 4 | 0 | 0 |
| **SA STATE TOTAL** | | **211** | **53** | **5,078,298** |

| | | | | |
|---|---|---|---|---|
| WA | Curtin University of Technology | 17 | 2 | 120,380 |
| WA | Edith Cowan University | 4 | 1 | 85,665 |
| WA | Keogh Institute for Medical Research | 1 | 0 | 0 |
| WA | Murdoch University | 7 | 1 | 55,095 |
| WA | Royal Perth Hospital | 5 | 0 | 0 |
| WA | Sir Charles Gairdner Hospital Perth | 2 | 1 | 130,095 |
| WA | TVW Telethon Institute for Child Health Research | 0 | 0 | 0 |
| WA | University of Western Australia | 133 | 38 | 4,472,302 |
| WA | Western Australian Institute for Medical Research | 2 | 2 | 281,330 |
| **WA STATE TOTAL** | | **171** | **45** | **5,144,867** |

| | | | | |
|---|---|---|---|---|
| TAS | University of Tasmania | 20 | 2 | 134,551 |
| **TAS STATE TOTAL** | | **20** | **2** | **134,551** |

| | | | | |
|---|---|---|---|---|
| ACT | Australian National University | 23 | 5 | 386,615 |
| ACT | The Canberra Hospital | 4 | 2 | 306,520 |
| ACT | The University of Canberra | 2 | 0 | 0 |
| **ACT STATE TOTAL** | | **29** | **7** | **693,135** |

| | | | | |
|---|---|---|---|---|
| NT | Menzies School of Health Research | 18 | 3 | 273,355 |
| NT | Northern Territory University | 1 | 0 | 0 |
| **NT STATE TOTAL** | | **19** | **3** | **273,355** |

| | | | | |
|---|---|---|---|---|
| **NATIONAL TOTAL** | | **1,851** | **459** | **47,544,719** |

**Funding by Institution for Project Grants Commencing in 2002**

This table shows the total amount of funding (all years) awarded to NHMRC Project Grants commencing in 2002.

| State | Administration Institution | #of Applications | #Successful | Funding Total |
|---|---|---|---|---|
| NSW | Australian Red Cross Blood Service, NSW | 1 | | |
| NSW | Centenary Institute of Cancer Medicine and Cell Biology | 10 | 4 | 1,420,000 |
| NSW | Charles Sturt University | 2 | | |
| NSW | Children's Medical Research Institute | 7 | 4 | 1,685,000 |
| NSW | Garvan Institute of Medical Research | 18 | 3 | 1,190,000 |
| NSW | Heart Research Institute | 12 | 3 | 1,440,000 |

| | | | | |
|---|---|---|---|---|
| NSW | Institute of Dental Research | 1 | | |
| NSW | Macquarie University | 8 | 3 | 1,067,500 |
| NSW | NSW Cancer Council | 2 | 1 | 678,550 |
| NSW | Royal North Shore Hospital | 1 | | |
| NSW | Royal Prince Alfred Hospital | 15 | 2 | 720,000 |
| NSW | South Eastern Sydney Area Health Service | 1 | | |
| NSW | Southern Cross University | 3 | | |
| NSW | The Children's Hospital Westmead | 9 | 1 | |
| NSW | University of New England | 4 | 1 | 60,000 |
| NSW | University of New South Wales | 129 | 25 | 6,532,120 |
| NSW | University of Newcastle | 52 | 13 | 4,893,500 |
| NSW | University of Sydney | 205 | 57 | 20,870,326 |
| NSW | University of Technology Sydney | 10 | 1 | 65,000 |
| NSW | Victor Chang Cardiac Research Institute | 11 | 4 | 1,542,866 |
| NSW | Westmead Hospital | 11 | 3 | 555,800 |
| **NSW State Total** | | **512** | **125** | **42,720,662** |

| | | | | |
|---|---|---|---|---|
| VIC | Alfred Hospital | 3 | | |
| VIC | Anti - Cancer Council of Victoria | 6 | 3 | 1,073,000 |
| VIC | Austin Hospital Medical Research Foundation | 6 | 1 | 270,000 |
| VIC | Austin Research Institute | 20 | 6 | 2,865,000 |
| VIC | Baker Medical Research Institute | 8 | | |
| VIC | Bionic Ear Institute | 5 | 1 | |
| VIC | Brain Research Institute | 6 | | |
| VIC | Centre for Eye Research Australia Ltd | 2 | | |
| VIC | Deakin University | 21 | 1 | 555,000 |
| VIC | Geelong Hospital | 1 | | |
| VIC | Heart Research Centre | 1 | | |
| VIC | Howard Florey Institute | 5 | | |
| VIC | La Trobe University | 20 | 7 | 2,277,500 |
| VIC | Ludwig Institute for Cancer Research | 9 | 4 | 1,425,000 |
| VIC | Macfarlane Burnet Institute for Medical Research and Public Health | 16 | 2 | |
| VIC | Melbourne Health | 8 | 1 | |
| VIC | Mental Health Research Institute of Victoria | 7 | 2 | 725,000 |
| VIC | Monash University | 143 | 27 | 11,471,350 |
| VIC | Murdoch Childrens Research Institute | 21 | 11 | 2,933,650 |

| | | | | |
|---|---|---|---|---|
| VIC | National Ageing Research Institute | 7 | 1 | 205,000 |
| VIC | National Stroke Foundation | 1 | | |
| VIC | National Vision Research Institute of Australia | 1 | | |
| VIC | Peter MacCallum Cancer Institute | 1 | | |
| VIC | Prince Henry's Institute of Medical Research | 10 | 3 | 1,222,500 |
| VIC | Royal Melbourne Institute of Technology | 21 | 1 | 410,000 |
| VIC | Royal Women's Hospital, Melbourne | 7 | 1 | 225,000 |
| VIC | St. Vincent's Health | 7 | 3 | |
| VIC | St. Vincent's Institute of Medical Research | 8 | 1 | 450,000 |
| VIC | Swinburne University | 4 | | |
| VIC | The Jean Hailes Foundation | 1 | | |
| VIC | Turning Point Alcohol and Drug Centre | 3 | | |
| VIC | University of Ballarat | 1 | | |
| VIC | University of Melbourne | 203 | 53 | 18,213,700 |
| VIC | Victoria University of Technology | 4 | | |
| VIC | Walter and Eliza Hall Institute | 11 | 2 | 1,456,250 |
| **VIC State Total** | | **598** | **131** | **45,777,950** |

| | | | | |
|---|---|---|---|---|
| QLD | Bond University | 1 | | |
| QLD | Central Queensland University (CQU) | 1 | | |
| QLD | Griffith University | 16 | 3 | 508,500 |
| QLD | Injury Prevention and Control (Australia) Ltd | 1 | | |
| QLD | James Cook University | 7 | | |
| QLD | Mater Misericordiae Hospital / Mater Medical Research Institute | 5 | | |
| QLD | Prince Charles Hospital | 7 | 1 | 675,000 |
| QLD | Queensland Institute of Medical Research | 14 | 3 | 1,518,000 |
| QLD | Queensland University of Technology | 18 | 3 | 716,000 |
| QLD | Royal Brisbane Hospital Research Foundation | 3 | | |
| QLD | Royal Children's Hospital, Brisbane | 1 | | |
| QLD | The Dr Edward Koch Foundation Limited | 1 | | |
| QLD | University of Queensland | 171 | 38 | 12,668,200 |
| QLD | University of Southern Queensland | 1 | | |
| QLD | Wesley Research Institute | 3 | 1 | 420,000 |
| **QLD State Total** | | **250** | **49** | **16,505,700** |

| | | | | |
|---|---|---|---|---|
| SA | Flinders University of South Australia | 48 | 5 | 2,032,000 |
| SA | Institute of Medical and Veterinary Science | 10 | | |
| SA | Repatriation General Hospital, Daw Park | 4 | | |
| SA | Royal Adelaide Hospital | 6 | 1 | 625,000 |
| SA | The Queen Elizabeth Hospital | 2 | | |
| SA | University of Adelaide | 111 | 35 | 13,472,730 |
| SA | University of South Australia | 13 | 1 | 191,500 |
| SA | Women's and Children's Hospital | 2 | | |
| **SA State Total** | | **196** | **42** | **16,321,230** |
| WA | Curtin University of Technology | 24 | 1 | 135,000 |
| WA | Edith Cowan University | 4 | 1 | 150,000 |
| WA | Murdoch University | 9 | 1 | 330,000 |
| WA | Royal Perth Hospital | 3 | | |
| WA | University of Western Australia | 152 | 34 | 10,505,000 |
| WA | University of Western Sydney, Nepean | 7 | | |
| WA | University of Wollongong | 15 | 4 | 1,077,500 |
| WA | Western Australian Institute for Medical Research | 3 | | |
| **WA State Total** | | **217** | **41** | **12,197,500** |
| TAS | University of Tasmania | 16 | 5 | 3,201,636 |
| **TAS State Total** | | **16** | **5** | **3,201,636** |
| ACT | Australian National University | 29 | 7 | 3,112,500 |
| ACT | The Canberra Hospital | 1 | | |
| ACT | University of Canberra | 2 | | |
| **ACT State Total** | | **32** | **7** | **3,112,500** |
| NT | Menzies School of Health Research | 17 | 4 | 1,293,500 |
| **NT State Total** | | **17** | **4** | **1,293,500** |
| **NATIONAL TOTAL** | | **1838** | **404** | **141,130,678** |

**Funding by Institution for Project Grants Commencing in 2003**

This table shows the total amount of funding (all years) awarded to NHMRC Project Grants commencing in 2003.

| State | Administration Institution | #of Applications | #Successful | Funding Total |
|---|---|---|---|---|
| NSW | Charles Sturt University | 3 | | |
| NSW | Children's Medical Research Institute | 5 | 2 | 870,000 |
| NSW | Garvan Institute of Medical Research | 17 | 11 | 5,030,000 |
| NSW | Heart Research Institute | 3 | | |
| NSW | Institute of Dental Research | 2 | | |
| NSW | Macquarie University | 8 | 2 | 525,000 |
| NSW | New England Area Health Service | 1 | | |
| NSW | Royal North Shore Hospital | 3 | 1 | 369,000 |
| NSW | Royal Prince Alfred Hospital | 10 | 3 | 840,000 |
| NSW | The Children's Hospital Westmead | 16 | 4 | 1,120,000 |
| NSW | University of New England | 5 | | |
| NSW | University of New South Wales | 142 | 19 | 6,123,678 |
| NSW | University of Newcastle | 63 | 9 | 2,611,500 |
| NSW | University of Sydney | 190 | 51 | 17,528,565 |
| NSW | University of Technology Sydney | 7 | | |
| NSW | University of Western Sydney, Hawkesbury | 3 | | |
| NSW | University of Wollongong | 5 | | |
| NSW | Victor Chang Cardiac Research Institute | 8 | 4 | 1,535,000 |
| NSW | Westmead Hospital | 5 | | |
| **NSW STATE TOTAL** | | **496** | **106** | **36,552,743** |
| VIC | Alfred Hospital | 5 | | |
| VIC | Anti - Cancer Council of Victoria | 6 | 2 | 297,500 |
| VIC | Austin Hospital Medical Research Foundation | 2 | | |
| VIC | Austin Research Institute | 10 | 3 | 1,380,000 |
| VIC | Baker Medical Research Institute | 17 | 7 | 2,845,500 |
| VIC | Brain Research Institute | 5 | 2 | 504,000 |
| VIC | Deakin University | 9 | 2 | 573,750 |
| VIC | Howard Florey Institute | 16 | 3 | 1,235,000 |
| VIC | International Diabetes Institute Inc | 2 | 1 | 2,600,000 |
| VIC | La Trobe University | 17 | 3 | 2,643,000 |
| VIC | Ludwig Institute for Cancer Research | 8 | 7 | 2,735,000 |

| | | | | |
|---|---|---|---|---|
| VIC | Macfarlane Burnet Institute for Medical Research and Public Health | 14 | 1 | 330,000 |
| VIC | Melbourne Health | 9 | 1 | 420,000 |
| VIC | Mental Health Research Institute of Victoria | 6 | 3 | 950,000 |
| VIC | Monash University | 148 | 34 | 11,507,460 |
| VIC | Murdoch Childrens Research Institute | 39 | 8 | 3,507,000 |
| VIC | National Ageing Research Institute | 5 | | |
| VIC | National Stroke Foundation | 3 | | |
| VIC | Prince Henry's Institute of Medical Research | 11 | | |
| VIC | Royal Melbourne Institute of Technology | 10 | 1 | 260,000 |
| VIC | Royal Women's Hospital, Melbourne | 4 | | |
| VIC | St. Vincent's Health | 2 | 1 | 843,000 |
| VIC | St. Vincent's Institute of Medical Research | 10 | 5 | 2,110,000 |
| VIC | Swinburne University | 4 | | |
| VIC | The Jean Hailes Foundation | 3 | | |
| VIC | Turning Point Alcohol and Drug Centre | 2 | | |
| VIC | University of Ballarat | 1 | 1 | 192,000 |
| VIC | University of Melbourne | 185 | 46 | 17,618,440 |
| VIC | Victoria University of Technology | 4 | 2 | 440,000 |
| VIC | Walter and Eliza Hall Institute | 14 | 8 | 2,725,000 |
| **VIC STATE TOTAL** | | **571** | **141** | **55,716,650** |
| QLD | Bond University | 2 | | |
| QLD | Central Queensland University | 1 | | |
| QLD | Griffith University | 18 | 2 | 765,000 |
| QLD | James Cook University | 6 | 2 | 689,000 |
| QLD | Mater Misericordiae Hospital / Mater Medical Research Institute | 7 | 2 | 915,000 |
| QLD | Prince Charles Hospital | 3 | | |
| QLD | Queensland Cancer Fund | 2 | | |
| QLD | Queensland Institute of Medical Research | 36 | 12 | 5,545,500 |
| QLD | Queensland University of Technology | 17 | 2 | 550,000 |
| QLD | Royal Brisbane Hospital | 1 | 1 | 190,000 |
| QLD | Royal Children's Hospital, Brisbane | 1 | 1 | 443,000 |
| QLD | University of Queensland | 165 | 37 | 12,890,350 |
| QLD | University of Southern | 3 | | |

| | | | | |
|---|---|---|---|---|
| | Queensland | | | |
| QLD | University of the Sunshine Coast | 1 | | |
| QLD | Wesley Research Institute | 1 | | |
| **QLD STATE TOTAL** | | **264** | **59** | **21,987,850** |
| SA | Flinders University of South Australia | 45 | 11 | 3,806,500 |
| SA | Institute of Medical and Veterinary Science | 6 | 1 | 420,000 |
| SA | Royal Adelaide Hospital | 8 | 2 | 435,000 |
| SA | The Queen Elizabeth Hospital | 1 | | |
| SA | University of Adelaide | 96 | 22 | 7,232,250 |
| SA | University of South Australia | 8 | | |
| **SA STATE TOTAL** | | **164** | **36** | **11,893,750** |
| WA | Curtin University of Technology | 18 | 3 | 895,700 |
| WA | Edith Cowan University | 6 | 1 | 65,000 |
| WA | Fremantle Heart Institute | 1 | | |
| WA | Murdoch University | 13 | 2 | 930,000 |
| WA | Royal Perth Hospital | 3 | | |
| WA | Sir Charles Gairdner Hospital Perth | 8 | | |
| WA | University of Western Australia | 120 | 36 | 12,662,267 |
| **WA STATE TOTAL** | | **169** | **42** | **14,552,967** |
| TAS | University of Tasmania | 18 | 2 | 420,000 |
| **TAS STATE TOTAL** | | **18** | **2** | **420,000** |
| ACT | Australian National University | 50 | 21 | 7,182,885 |
| ACT | The Canberra Hospital | 3 | 1 | 187,000 |
| ACT | University of Canberra | 2 | | |
| **ACT STATE TOTAL** | | **55** | **22** | **7,369,885** |
| NT | Menzies School of Health Research | 16 | 7 | 4,112,250 |
| NT | Northern Territory University | 2 | | |
| **NT STATE TOTAL** | | **18** | **7** | **4,112,250** |
| **NATIONAL TOTAL** | | **1755** | **415** | **152,606,095** |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-028

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC PROJECT GRANTS

Written Question on Notice

Senator Harradine asked:

(a) Would you please explain the system by which NHMRC project grant awards are made and how this system protects against discrimination against smaller institutions such as the University of Tasmania?
(b) The current grant system is a closed process where an applicant does not have the opportunity to rebut arguments against a particular project, nor to understand why a grant may be accepted or rejected. Are you considering establishing a more open and transparent process for grants? If not, why not?
(c) Is it correct that only grant holders sit on the selection committee? If so, would this not tend to naturally lead to a more closed process where like-minded researchers select each other's projects?

Answer:

(a) Each year, NHMRC Project Grant applications are allocated to Grant Review Panels (GRPs) based on the field of research selected by the applicant. There are approximately 20 GRPs covering a broad range of research areas based on the Australian Bureau of Statistics Fields of Research. The membership of the GRPs is determined by the NHMRC Research Committee after taking into consideration the number, and type of applications received that year, ensuring that appropriate expertise is available to review each application. Additional consideration is also given to the make-up of GRPs relevant to members' gender and geographical location, and where possible one third of GRP members are new each year. There are 11 members of each GRP. Applications are then reviewed based on Significance and Innovation, Scientific Quality, and the Track Record of the applicants.

The Project Grant peer review process can be summarised as follows:

- Each application is allocated to a GRP;
- Primary and Secondary Spokespersons are nominated from within that GRP;

- Spokespersons, in consultation with the GRP Chair, nominate three appropriate independent assessors, taking into consideration the applicant's preferred assessor, and any nominated non-assessor.
- The GRP reviews all Assessors' reports and questions, and formulates additional questions to the applicant as necessary;
- Applicants respond to Assessor and GRP comments and questions;
- The GRP meets to review, and rank each application assigned to the panel.

The Project Grants Committee (a subcommittee of the NHMRC Research Committee) reviews the final GRP rankings, and then provides recommendations to Research Committee. The agreed recommendations are then provided to the Minister for Health and Ageing for approval. An applicant's Administering Institution is not a factor in selecting the most excellent research proposals.

(b) During the peer review process the applicant is given the opportunity to respond, in writing, to questions and comments raised by the independent assessors and the GRP. The applicant's response to these questions and comments is then taken into consideration by the GRP. In addition to the initial rebuttal if, during the GRP meetings issues not previously addressed are raised, the GRP has the option to ask further questions of the applicant.

The NHMRC constantly reviews its processes and procedures, which is done by seeking feedback from the research community. The NHMRC considers the current process of reviewing NHMRC Project Grants as fair, equitable and transparent, therefore there is no substantial changes to this process currently under consideration.

(c) The peer review process is conducted in two stages, the first of which involves three independent assessors, one of which can be nominated by the applicant. These assessors are not selected on the basis of their research funding, but on their expertise in the research field.

The question of grantholders participating in the process applies only to the second stage where the GRP members review the application, the Assessor's comments and the Applicant's responses to the Assessor and GRP comments and questions. The NHMRC adheres strictly to the principles of peer review, where the most robust criteria of a "peer" is the ability of a person to compete successfully in the arena of nationally or internationally competitive peer-reviewed research grant processes. If a researcher does not, or has not recently, held funding gained through such a process then it is unlikely that they will be perceived, by the colleagues for whom they sit in judgement, as legitimate and credible peers. Gaining competitive research funding is regarded internationally as one of the best indications of a researcher's merit, and therefore, provides a good indication of their appropriateness to serve on a GRP. There are 11 such members of each grant review panel drawn from the research community across Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-029

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

How will the NHMRC Licensing Committee ensure that there is a proof of the date on which the embryo was created before it can be defined as an excess ART embryo? What type of proof will the Committee require?

Answer:

Proof of date of creation is not required for an embryo to be defined as an excess ART embryo. However, Section 24(3) of the *Research Involving Human Embryos Act 2002* states that:

> If a licence authorises the use of an excess ART embryo that may damage or destroy the embryo, the licence is subject to the condition that such use is authorised only in respect of an embryo created before 5 April 2002.

Before it issues a licence for activities that may damage or destroy an embryo, the NHMRC Licensing Committee must be satisfied that protocols are in place to ensure that only embryos created before 5 April 2002 are used. If a licence is issued, the licence holder cannot start work until they have notified the Licensing Committee that the embryos to be used were created before 5 April 2002.

Inspectors appointed by, and reporting to the Licensing Committee will check records held by licence holders and IVF clinics to ensure that licence holders are in compliance with these requirements of the legislation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-030

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC LICENSING COMMITTEE MEMBERSHIP

Written Question on Notice

Senator Harradine asked:

I understand that members of the Licensing Committee will have expertise in research ethics, research, ART, law, and consumer issues relating to both disability and ART. Will all the members of the Licensing Committee be supporters of embryo research, leading to more liberal interpretations of the legislation, or will there be some balance on the Committee?

Answer:

The broad membership of the Licensing Committee and the process for appointment of members is set out in sections 13 to 17 of the *Research Involving Human Embryos Act 2002*. The NHMRC Secretariat is assisting the Minister to finalise nominations to the Licensing Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-031

OUTCOME 9: HEALTH INVESTMENT

Topic: PARENTAL CONTROL OF EMBRYOS

Written Question on Notice

Senator Harradine asked:

Can parent donors of embryos specify that they do not want the derivatives of their donated embryo to be used or to be sent overseas?

(a) If so, how would this system operate?
(b) Will consent forms be required to specify this option?
(c) How will embryos and their derivatives be tracked?
(d) How will this be monitored by the Licensing Committee?

Answer:

(a-b) Section 24(2) of the *Research Involving Human Embryos Act 2002* states that a licence is subject to the condition that "the use of an excess ART embryo must be in accordance with any restrictions to which the proper consent under subsection (1) is subject." This is consistent with the legislative scheme determined by COAG:

> Council agreed that research be allowed only on existing excess ART embryos, that would otherwise have been destroyed, under a strict regulatory regime, including requirements for the consent of donors and that the embryos were in existence at 5 April 2002. Donors will be able to specify restrictions, if they wish, on the research uses of such embryos.

That is, consistent with the COAG Communique, the *Research Involving Human Embryos Act 2002* does not extend to regulating the use of derivatives of embryos, such as stem cells.

While the legislation allows donors to specify conditions about the uses of embryos covered by the licence, this does not extend beyond the activities covered by the licence.

However, concerns of donors are addressed during the process of obtaining proper consent, through the full disclosure of information as required under relevant NHMRC Guidelines. If the donors still have concerns following provision of such information, then they may refuse to give consent.

Before it issues a licence for activities that may damage or destroy an embryo, the NHMRC Licensing Committee must be satisfied that protocols are in place to ensure that proper consent has been obtained before an excess ART embryo is used under the licence.

(c) As indicated above, the legislation does not extend to derivatives of embryos. Before they can undertake any work covered by the licence, licence holders must report to the Licensing Committee when they have obtained proper consent and that the embryos were created before 5 April 2002 (if the use may damage or destroy the embryos).

(d) Inspectors appointed by, and reporting to the Licensing Committee will check records held by licence holders and IVF clinics to ensure that licence holders are in compliance with these requirements of the legislation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-032

OUTCOME 9: HEALTH INVESTMENT

Topic: COUNSELLING OF PARENTS WHO DONATE EMBRYOS

Written Question on Notice

Senator Harradine asked:

(a) What form of counselling will be available to parents who are considering donating their embryos to research?
(b) Will the counselling be independent of the self-interested ART clinics or research organisations?

Answer:

(a) While the *Research Involving Human Embryos Act (2002)* does not specify counselling requirements, these are bound within the consent provisions of the Act which refer to the NHMRC *Ethical guidelines on assisted reproductive technology (1996).* These guidelines state that counselling should be an integral part of any ART program, and be available as part of long-term follow up. Theses guidelines are currently being revised through a public consultation process. The draft guidelines propose that all those participating in the donation of embryos must be offered counselling. The precise provisions in these draft guidelines may be revised in light of submissions received during the public consultation process currently underway.

(b) The revised draft guidelines propose that clinics should provide participants with information about professional counsellors who are independent of the clinic. The precise provisions in these draft guidelines may be revised in light of submissions received during the public consultation process currently underway.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-033

OUTCOME 9: HEALTH INVESTMENT

Topic: LICENSING SYSTEM TO MONITOR RESEARCHERS

Written Question on Notice

Senator Harradine asked:

A system has been set up in the legislation to monitor researchers or institutions which have obtained licences from the Licensing Committee. What active steps will the NHMRC be taking to ensure that people do not evade the licensing system altogether and operate outside the regulations?

Answer:

Given the strong penalties under the *Research Involving Human Embryos Act 2002*, the NHMRC has been working to ensure that organisations are aware of their obligations under the new legislative scheme. This included writing to IVF clinics and researchers and developing comprehensive information kits.

As described under part 3 (Section 33-41) of the *Research Involving Human Embryos Act 2002*, there will be ongoing monitoring and inspection of compliance with the prohibited practices outlined in the *Prohibition of Human Cloning Act 2002* and the offence provisions of the *Research Involving Human Embryos Act 2002*, as well as compliance with conditions of licences issued by the NHMRC Licensing Committee. The NHMRC Licensing Committee will supplement this surveillance with investigation of complaints and other matters raised by third parties.

In relation to investigating activities undertaken by a person who is not a licence holder, inspectors can enter premises with the consent of the occupier. Further, the Australian Federal Police has comprehensive powers under the *Crimes Act 1914* to investigate suspected offences against Commonwealth legislation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-034

OUTCOME 9: HEALTH INVESTMENT

Topic: REPRODUCTIVE TECHNOLOGY ACCREDITATION COMMITTEE

Written Question on Notice

Senator Harradine asked:

The Reproductive Technology Accreditation Committee of the Fertility Society of Australia is given an important role under the Research Involving Human Embryos Act.

(a) What is the procedure undertaken by RTAC to accredit ART clinics?
(b) How many times in the past five years has RTAC refused accreditation to an ART clinic?
(c) Please provide details of each clinic seeking accreditation including the name and the date of the application, and, for each clinic refused accreditation, with details of the date and reason for each refusal, whether the particular clinic was subsequently accredited and the date of that accreditation.
(d) Given that accredited ART centres are accredited by the Reproductive Technology Accreditation Committee of the Fertility Society of Australia, what steps is the Department taking to ensure that the accreditation process is adequate and that it is applied appropriately when assessing centres?

Answer:

(a) The NHMRC does not hold details of procedures undertaken by the RTAC. RTAC can be contacted through the Secretariat of the Fertility Society of Australia at *Waldron Smith Management, 61 Danks Street, Port Melbourne, Victoria 3207. Telephone (03) 9645 6359 and e-mail to* wscn@convention.net.au

(b) The NHMRC does not have this data. This information may be held by RTAC.

(c) The NHMRC does not have this information. This information may be held by RTAC.

(d) At the Council of Australian Governments (COAG) meeting on 5 April 2002, Heads of Government agreed that:

*Accreditation by the Reproductive Technology Accreditation Committee (RTAC) of the Fertility Society of Australia should provide the basis for a nationally-consistent approach to the oversight of ART clinical practice in Australia, noting that compliance with the NHMRC/AHEC Ethical Guidelines on ART is a key requirement of RTAC accreditation*.

Given that COAG have decided that RTAC accreditation should form an acceptable basis for oversight of ART clinical practice in Australia, there are no current plans to investigate these processes further.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-035

OUTCOME 9: HEALTH INVESTMENT

Topic: COAG COMMUNIQUE ETHICS COMMITTEE

Written Question on Notice

Senator Harradine asked:

The April 2002 COAG Communiqué states that "The Council also agreed to establish an Ethics Committee with membership jointly agreed by the Council to report to the Council within 12 months on protocols to preclude the creation of embryos specifically for research purposes, with a view to reviewing the necessity for retaining the restriction on embryos created on or after 5 April 2002."

(a) Please provide details of this ethics committee including names and the CVs of the members, the detailed work plan of the committee and progress so far.
(b) Please explain how a report on protocols to preclude the creation of embryos specifically for research - apparently a compliance issue - relates to the planned review of retaining the restriction on embryos created on or after 5 April last year.

Answer:

(a) The ethics committee with membership agreed by the Council of Australian Governments (COAG) is the Committee to Revise the Ethical Guidelines on Assisted Reproductive Technology (CREGART). CREGART is a sub-committee of the Australian Health Ethics Committee (AHEC).

The members of CREGART are:

| | |
|---|---|
| • A/Professor Bernadette Tobin | Chair & a member of AHEC |
| • Professor Geoffrey Bishop | An Obstetrician |
| • Ms Belinda Byrne | Member of AHEC |
| • Dr Peter Illingworth | A provider of IVF services (resigned from this task November 2002) |
| • Professor John Mattick | Member of AHEC with experience in Medical research |

| | |
|---|---|
| • Dr Sandra Webb | Member of AHEC with experience in public health research |
| • Mr Henry Wellsmore | Experience in counselling in an IVF clinic |
| • Emeritus Professor Douglas Saunders | A provider of IVF services (appointed on 18 February 2003) |

The Minister for Health and Ageing wrote to the Chair of AHEC on 28 August 2002 requesting that CREGART take on this task. CREGART commenced work in October 2002 and submitted its report to COAG on 4 April 2003.

(b) This was determined by the Council of Australian Governments at its meeting of 5 April 2002. In its Communique, COAG stated:

> *Having noted the range of views across the community, including concerns that such research could lead to embryos being created specifically for research purposes, the Council agreed that research be allowed only on existing excess ART embryos, that would otherwise have been destroyed, under a strict regulatory regime, including requirements for the consent of donors and that the embryos were in existence at 5 April 2002.*

That is, COAG established the 5 April 2002 restriction in response to concerns regarding the possibility of embryos being created specifically for research.

In relation to removing the restriction, the COAG Communique went on to request the report "on protocols to preclude the creation of embryos specifically for research purposes, with a view to reviewing the necessity for retaining the restriction on embryos created on or after 5 April 2002."

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-036

OUTCOME 9: HEALTH INVESTMENT

Topic: COAG COMMUNIQUE

Written Question on Notice

Senator Harradine asked:

The April 2002 COAG Communiqué states that "The Council also agreed to request the NHMRC to report within 12 months on the adequacy of supply and distribution for research of excess ART embryos which would otherwise have been destroyed." Please provide a copy of that report or, if it is not completed, a copy of the draft. If the report is not completed, please provide me with details of progress with the report, the names and affiliations of those working on the report and the expected delivery date.

Answer:

This report was required by COAG by 5 April 2003. The report, which was submitted to COAG on 4 April 2003, is not available outside the COAG process.

At its 143rd meeting (9 August 2002), the National Health & Medical Research Council agreed to establish a steering committee to oversee development of the report. The membership of the steering committee is:

Professor Richard Kefford (Research Committee) - Chair
Ms Michele Kosky (Council)
Dr Peter Joseph (Health Advisory Committee)
Dr Sandra Webb (Australian Health Ethics Committee)
Professor Jock Findlay (Research Committee nominee)
Professor Judith Whitworth (Research Committee nominee)

Adelaide Research & Innovations Pty Ltd, a company established under the auspice of the University of Adelaide, were contracted to assist with the preparation of the report. The individual ARI consultants involved were Dr Sheryl de Lacey, Dr Michael Davies and Professor Robert Norman (see answers to QoN E03-040 & E03-041).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-037

OUTCOME 9: HEALTH INVESTMENT

Topic: COAG COMMUNIQUE

Written Question on Notice

Senator Harradine asked:

The April 2002 COAG Communiqué refers to the "Health Minister's Report". Please provide a copy of the report.

Answer:

The NHMRC is unable to supply this document. A similar request was made during the hearings of the Senate Community Affairs Legislation Committee in September 2002. In response, the NHMRC indicated that this request could be addressed to the secretariat of the Australian Health Minister's Conference.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-038

OUTCOME 9: HEALTH INVESTMENT

Topic: ETHICS IN HUMAN RESEARCH CONFERENCE

Written Question on Notice

Senator Harradine asked:

I understand that the NHMRC is conducting an Ethics in Human Research conference and a Research Ethics Training Day in April. The list of keynote speakers does not appear to include a broad diversity speakers from different ethical perspectives. Would it not be appropriate to encourage a diversity of views so that the attendees can be exposed to a broad range of views on ethics?

Answer:

The Ethics in Human Research Conference provided a forum for the discussion of ethical review systems and issues and experiences in the implementation of the *NHMRC National Statement on Ethical Conduct in Research Involving Humans* (1999). The themes of the conference were:

- Regulatory models and international perspectives on ethical review of research;
- Systemic issues in ethical review of research;
- Human Research Ethics Committee (HREC) practice.
- Responsibilities to participants and the public; and
- Research populations requiring special ethical consideration.

13 invited speakers addressed the conference: 3 international and 10 national. The remaining 58 speakers were drawn from submitted abstracts. A call for abstracts was issued in September 2002 and circulated widely. Any person with an interest in research ethics was eligible. These 71 speakers provided the audience with a diversity of views on ethical review systems and the implementation of the National Statement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-039

OUTCOME 9: HEALTH INVESTMENT

Topic: VICTORIAN STEM CELL CODE OF PRACTICE

Written Question on Notice

Senator Harradine asked:

(a) Did the Department provide any funding to the Victorian working group on the stem cell code of practice?
(b) Please provide names of the members of the working party. How were they selected?
(c) Did the NHMRC contribute to the formulation of the Victorian stem cell code of practice? If so, in what way?

Answer:

(a) No.

(b) The NHMRC has no knowledge of this process.

(c) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-040

OUTCOME 9: HEALTH INVESTMENT

Topic: FOLLOW-ON QUESTION FROM E02-017

Written Question on Notice

Senator Harradine asked:

In reply to estimates question E02-017, the Department noted that "Adelaide Research and Innovation Pty Ltd" had been contracted to assist with preparing a report on the adequacy of supply of so-called excess human embryos. The Department noted that the consultant will be consulting with researchers, ART service providers and consumers of ART services, but it does not appear that there will be broader consultation with others who may be able to offer expert views. For instance, a view on the adequacy of supply depends very much on the approach taken to certain research. Someone in the ART industry is more likely to want to use embryos in their research to a certain end while a researcher from another industry might undertake that research in a different way to the same end, but which does not require embryos.

(a) Is it appropriate to restrict consultation to those people who are involved in the ART industry?
(b) Is this not likely to result in special pleading by self-interested parties and what is the evidence for your position?
(c) Why would you not take a broader and open approach to consultation, including seeking the views of individuals and organisations which do not have a stake in the ART industry?

Answer:

The COAG requested a report from the NHMRC on the 'adequacy of supply and distribution for research of excess ART embryos which would otherwise have been destroyed' and the NHMRC sought assistance with the development of this report. As indicated in the response to E02-017, the consultant was asked to:

- consult widely with researchers, ART service providers, consumers of ART services and other relevant stakeholders to gather the information required to develop a report to be presented to COAG by 5 April 2003 which will provide information on numbers of excess ART embryos available for research, and issues affecting the adequacy of supply and distribution for research; and
- gather information on how issues related to the use of excess ART embryos for research are being managed in comparable countries such as Canada, USA, and the UK; and,
- suggest possible solutions to supply and access issues identified during these consultations.

As in all matters coming before COAG from expert groups, COAG members make decisions having regard to a wide range of perspectives.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-042

OUTCOME 9: HEALTH INVESTMENT

Topic: FOLLOW-UP ON EARLIER ANSWERS

Written Question on Notice

Senator Harradine asked:

(a) In answer to question E02-018 you noted that the University of Queensland through its HREC had given itself human ethics approval for a project on "improving first trimester screening …". Would you please provide me with a copy of the HREC report explaining the reasons for the approval.
(b) In answer to question E02-018 you noted that you were awaiting confirmation that the University of Adelaide had given itself human ethics approval through its HREC for a project on "GM-CSF regulation of preimplantation embryo development". Would you please provide me with a copy of the HREC report explaining the reasons for any approval.

Answer:

(a) The grant titled *Improving first trimester screening by combining rapid MF-PCR of PAP smears with nuchal ultrasound scanning* (Chief Investigator Dr Ian Findlay, University of Queensland), was included in error in the answer to Question E02-018. This grant involves screening of pregnant women during the first trimester of pregnancy, rather than research involving human embryos.

The NHMRC does not have, or require, Human Research Ethics Committees (HRECs) to provide reports that explain the reason for approving research involving humans on projects funded by the NHMRC. The NHMRC relies on the independence of the HREC to review the proposed research in accordance with The NHMRC's *National Statement on Ethical Conduct in Research Involving Humans*.

The NHMRC's *National Statement on Ethical Conduct in Research Involving Humans* requires that all institutions or organisations that receive NHMRC funding for research to establish a HREC and to subject all research relating to humans, whether funded by the NHMRC or not, to ethical review by that committee.

The Deed of Agreement between the Commonwealth and an Administering Institution sets out the following clearance requirements in relation to NHMRC funded research involving humans:

- All research involving humans shall be conducted in accordance with the requirements of the *National Statement on Ethical Conduct in Research Involving Humans* (1999) and associated guidelines, as amended from time to time.

- Approval shall be obtained from the relevant HREC before commencement of the Project, and shall be maintained for the duration of the Project. Institutions and HRECs shall be responsible for monitoring the conduct of the project and ensuring that ethical approval is obtained for amendments to the Project.

(b) Please refer to the answer to part (a) of this question in relation to the provision of HREC reports.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-043

OUTCOME 9: HEALTH INVESTMENT

Topic: FOLLOW-UP ON EARLIER ANSWERS

Written Question on Notice

Senator Harradine asked:

In answer to question E02-019 you declined to provide documentation to prove that the National University Hospital of Singapore had provided ethics approval for the extraction and export of human embryonic stem cells to Australia.

(a) What ethical approval process is required by the Singapore Government before embryos or embryonic stem cells can be exported from Singapore?
(b) What approval processes does the NHMRC require before imported embryos or human ES cells can be used in research?
(c) What monitoring does the NHMRC undertake of embryos or embryonic stem cells imported into Australia?

Answer:

(a) The National Health and Medical Research Council does not hold this information.

(b-c) Imported human embryos are subject to the same regulatory requirements as embryos created in Australia. The regulatory requirements are set out in the *Research Involving Human Embryos Act 2002.*

In relation to human embryonic stem cells imported into Australia, in September 2001 AHEC issued interim advice to human research ethics committees entitled, *Information for Human Research Ethics Committees Sheet Number 5 – Stem cell research.* This interim advice is provided at Attachment 1.

**Attachment 1**

# INFORMATION FOR HUMAN RESEARCH ETHICS COMMITTEES SHEET NUMBER 5 – STEM CELL RESEARCH

**The Australian Health Ethics Committee has been approached by human research ethics committees (HRECs) seeking advice on how to review research protocols that involve stem cell research.**

The following guidance is interim. Formal guidelines will be developed by AHEC in the context of its review of the 1996 NHMRC *Ethical guidelines on assisted reproductive technology*.

1. Research on stem cell lines derived from human embryos should be considered in the same way as any other research on human products (eg blood, tissue). All research proposals involving the use of stem cell lines derived from human embryos should be presented to an HREC for consideration.

2. The *Ethical guidelines on assisted reproductive technology* (1996) only permit destructive research on embryos under certain exceptional circumstances (section 6.4). If the stem cell lines have been derived through destructive research on embryos that meets the conditions laid down in these sections, then research on stem cell lines derived from human embryos is not explicitly prohibited.

3. In considering such research the HREC must consider whether the stem cell lines derived from human embryos have been derived in an appropriate manner (*Ethical guidelines on assisted reproductive technology* (1996) sections 6.4 and 11.1).

4. If derived in Australia, the research leading to the development of the stem cell lines must have occurred:

    - under the auspices of an HREC operating in accordance with the requirements of the *National Statement on ethical conduct in research involving humans* (1999) and the *Ethical guidelines on assisted reproductive technology* (1996); and

    - in compliance with prevailing Commonwealth and State or Territory legislation.

5. If the stem cell line derived from human embryos was imported to Australia, the HREC should endeavour to confirm that the cell line was developed in accordance with the:

    - *Ethical guidelines on assisted reproductive technology* (1996) (sections 6 and 11); and
    - *National Statement on ethical conduct in research involving humans* (1999) (paragraph 1.21).

    Two necessary considerations are that the embryo from which the stem cell line was derived was excess to an IVF program and that the donors gave informed consent.

6. If there are doubts regarding the origin of a stem cell line, or the requirements of Australian standards can not be satisfied, then the HREC should not permit the research to proceed.

AHEC has commenced a review of the *Ethical Guidelines on assisted reproductive technology* and related publications. This review will include wide public consultation. Pending the outcome of that review, HRECs are to be guided by this Information Sheet.

*Signed and despatched*

Dr Kerry J. Breen
Chairperson
Australian Health Ethics Committee

21 September 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-041

OUTCOME 9: HEALTH INVESTMENT

Topic: ADELAIDE RESEARCH AND INNOVATION PTY LTD

Written Question on Notice

Senator Harradine asked:

(a) Please provide details of the company Adelaide Research and Innovation Pty Ltd (ARI) and the CVs of the people working on the ARI project.
(b) Does the ARI have a history of consulting work in the area of assisted reproductive technology?
(c) If so, what is its history of work in the industry?
(d) If not, what sort of work does it normally undertake and in what industries?
(e) How much is the Department contracted to pay ARI?

Answer:

(a) Details on Adelaide Research & Innovations Pty Ltd can be found on their web-site at the following link http://www.adelaide.edu.au/ari/capability/

(b-d) Adelaide Research & Innovations Pty Ltd was selected through an open tender process managed by an independent steering committee established for the purpose (See Question: E03-036). The individual ARI consultants involved are Dr Sheryl de Lacey, Dr Michael Davies and Professor Robert Norman.

(e) An amount up to $97,000 has been contracted for the specified services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-070

OUTCOME 9: HEALTH INVESTMENT

Topic: FUNDING OF NHMRC GRANTS

Written Question on Notice

Senator Carr asked:

Please provide, for each university or other publicly-funded higher education institution, for the year 2002, their funding under the following program:

NH&MRC grants.

Answer:

The following table lists the National Health and Medical Research Council grants administered by universities and other publicly-funded higher education institutions for the year 2002:

| | |
|---|---|
| Australian National University | $7,890,116 |
| Curtin University of Technology | $1,052,041 |
| Deakin University | $907,233 |
| Edith Cowan University | $306,963 |
| Flinders University of South Australia | $6,362,881 |
| Griffith University | $1,271,393 |
| James Cook University | $183,901 |
| La Trobe University | $2,206,954 |
| Macquarie University | $478,574 |
| Monash University | $23,047,785 |
| Murdoch University | $444,531 |
| Queensland University of Technology | $1,098,233 |
| Royal Melbourne Institute of Technology | $435,916 |
| Swinburne University | $142,884 |
| University of Adelaide | $17,964,274 |
| University of Melbourne | $36,654,530 |
| University of New England | $30,110 |
| University of New South Wales | $16,993,159 |
| University of Newcastle | $4,758,460 |
| University of Queensland | $19,725,749 |
| University of South Australia | $338,190 |
| University of Sydney | $25,962,037 |

| | |
|---|---|
| University of Tasmania | $1,729,233 |
| University of Technology Sydney | $186,561 |
| University of Western Australia | $21,605,664 |
| University of Wollongong | $841,523 |
| Victoria University of Technology | $452,259 |

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 13 February 2003

Question: E03-050

OUTCOME 9: HEALTH INVESTMENT

Topic: HEALTH*INSITE*

Written Question on Notice

Senator Harradine asked:

(a) I understand you are responsible for the Health*Insite* Internet health portal. Health*Insite* includes links to sites that promote abortion and others which are opinion pieces advocating changes to liberalise Australian abortion policy. Is it appropriate for a government department to publicly promote a change to government policy?
(b) The site contains links to information on various methods of contraception while not offering information on natural methods of avoiding pregnancy, such as details of natural family planning. Would it not be appropriate to offer balanced information on the options available to people?
(c) While Health*Insite* has numerous links to family planning organisations, it does not refer to pregnancy support organisations, such as the Commonwealth-funded Australian Federation of Pregnancy Support Services (see http://www.pregnancysupport.com.au/) or Open Doors (http://www.opendoors.com.au/). Would it not be appropriate to offer links to organisations that assist women who wish to continue their pregnancies?

Answer:

(a) Health*Insite* has been developed by the Commonwealth government to provide Australians with a single gateway to quality health information, by linking users with information held on the sites of its information partners. It does not seek to represent or change government policy. Health*Insite*'s information partners include some of Australia's most authoritative health organisations, from hospitals and health departments to non-government organisations and self-help groups.

Each Health*Insite* information partner goes through a quality assessment process to ensure that their site is of the highest standard. An independent Editorial Board oversees Health*Insite*'s quality assessment process. This involves assessment by the potential information partner organisation and the Health*Insite* Editorial Team according to the criteria in *Approval of Content for HealthInsite*. The criteria cover: the quality processes used by the potential partner site to ensure the quality of their information; authority of the organisation; disclosure of sources of funding and sponsorship; currency; and technical issues including document formats, accessibility for people with disabilities, aesthetics and design and innovation. These criteria are based on the *HealthInsite Publishing Standards*, which partners agree to meet when they sign a deed of agreement with the Commonwealth. As a result, consumers can be confident that the information they are accessing through Health*Insite* is of high quality. Information about the Health*Insite* quality assessment process, the *HealthInsite Publishing Standards* and the assessment criteria, as well as a list of current Health*Insite* information partners are all published on Health*Insite*. The list can be found from the Health*Insite* home page under 'The concept'. The information about quality processes can be found from the home page of Health*Insite*, under 'About Health*Insite*', through the topic entry on 'Quality assessment of content for Health*Insite*'.

(b) Information on a range of family planning methods can be found under the topic 'Family planning and fertility'. There are a number of links to information on natural family planning from this area of the site. Health*Insite* includes a topic page on 'Pregnancy' that includes a variety of information providing support to pregnant women.

(c) Information partners can be self-nominated, identified by the Health*Insite* team within the Commonwealth Department of Health and Ageing, or identified by other information partners or members of the Health*Insite* Editorial Board. Links to organisations such as the Australian Federation of Pregnancy Support Services can be considered through these mechanisms. Potential candidate sites, once identified, are assessed in accordance with the Health*Insite* quality assessment process, the *HealthInsite Publishing Standards* and the assessment criteria published on Health*Insite*.