Community Affairs
Legislation Committee

Examination of Additional Estimates 2003-2004

Additional Information Received

VOLUME 4

Outcomes 3, 4, 5, 6, 7, 8, 9

HEALTH AND AGEING PORTFOLIO

MAY 2004

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 2003-2004

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the additional estimates hearing on 18 February 2004

HEALTH AND AGEING PORTFOLIO

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Residential care – structure may be accessed at:

http://www.ageing.health.gov.au/reports/acareps/rep2003.pdf
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Total Allocated Places by State / Territory
31 December 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	30,938	28,263	**59,201**	9,959	**69,160**
VIC	19,854	23,636	**43,490**	7,443	**50,933**
QLD	13,669	15,645	**29,314**	4,635	**33,949**
WA	6,679	8,096	**14,775**	2,456	**17,231**
SA	7,917	8,105	**16,022**	2,704	**18,726**
TAS	2,270	2,148	**4,418**	856	**5,274**
ACT	737	953	**1,690**	381	**2,071**
NT	347	243	**590**	564	**1,154**
Australia	**82,411**	**87,089**	**169,500**	**28,998**	**198,498**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and CACPs.

The figures do not include 5,889 residential places allocated in January 2004 through the 2003 Aged Care Approvals Round.

Total Allocated Ratio by State / Territory

31 December 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	47.9	43.8	**91.7**	15.4	**107.2**
VIC	42.3	50.3	**92.6**	15.8	**108.5**
QLD	42.7	48.9	**91.6**	14.5	**106.1**
WA	42.6	51.7	**94.3**	15.7	**110.0**
SA	47.1	48.2	**95.3**	16.1	**111.4**
TAS	46.8	44.3	**91.1**	17.6	**108.7**
ACT	36.2	46.8	**83.0**	18.7	**101.7**
NT	70.4	49.3	**119.6**	114.4	**234.0**
Australia	**44.9**	**47.5**	**92.4**	**15.8**	**108.3**

Total Operational Places by State / Territory

31 December 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	29,360	23,873	**53,233**	9,627	**62,860**
VIC	17,820	20,934	**38,754**	7,222	**45,976**
QLD	12,788	14,701	**27,489**	4,487	**31,976**
WA	6,040	7,017	**13,057**	2,375	**15,432**
SA	7,499	7,406	**14,905**	2,596	**17,501**
TAS	2,264	1,873	**4,137**	831	**4,968**
ACT	635	912	**1,547**	362	**1,909**
NT	324	223	**547**	542	**1,089**
Australia	**76,730**	**76,939**	**153,669**	**28,042**	**181,711**

Note:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and CACPs.

Total Operational Ratio by State / Territory

31 December 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	45.5	37.0	**82.5**	14.9	**97.4**
VIC	37.9	44.6	**82.5**	15.4	**97.9**
QLD	40.0	45.9	**85.9**	14.0	**99.9**
WA	38.5	44.8	**83.3**	15.2	**98.5**
SA	44.6	44.1	**88.7**	15.4	**104.1**
TAS	46.7	38.6	**85.3**	17.1	**102.4**
ACT	31.2	44.8	**76.0**	17.8	**93.7**
NT	65.7	45.2	**110.9**	109.9	**220.8**
Australia	**41.8**	**42.0**	**83.8**	**15.3**	**99.1**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-161

OUTCOME 3 ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PERFORMANCE ASSESSMENT MECHANISMS

Written Question on Notice

Senator Carr asked:

(a) Please provide full details of each of the performance assessment mechanisms linked to the pay outcomes or other financial reward of individual employees, including;
   (i) What are the current process/es of performance assessment within the portfolio agency? If more than one, please provide details of each, and the employee category it applies to.
   (ii) For each of the performance assessment process/es identified in (i), please list the range of outcome results an employee can achieve from each of the performance assessment processes identified in (i);
   (iii) For each of the performance assessment process/es identified in (i), what pay or other financial change is linked to each outcome or result for the employee from the performance assessment [ie, the pay increase or one-off bonus or classification or level change];
   (iv) For each of the performance assessments identified in (i), what is the classification level of employees subject to this performance assessment (eg SES, EL1, EL2, or APS and equivalent);
   (v) What is the principal industrial or other instrument governing each of the performance assessment mechanism/s (eg, the certified agreement or AWA);
   (vi) Does the performance assessment operate over a common cycle? Please provide the commencement and dates of the most recent full cycle of each of the assessment process/es.

(b) For each performance assessment mechanism in (a), advise the number of male and number of female employees at each possible outcome, by classification level for the most recent full cycle (if the performance mechanism does not operate over a common cycle – aggregate outcomes using the 2002-03 financial year).

Answer:

(a)
   (i) Staff performance is assessed against their job description and any agreed plan as part of a formal staff performance management system.
   (ii) Outcomes include performance bonus payment and qualify for any across the board increases flowing from the company annual review of the general movement in wages.

(iii) See (ii).
(iv) All employees.
(v) The Agency is a company under the Corporations Act. Therefore all staff are employed under an Employment Framework endorsed by its Board. Salary levels have been determined by the Chief Executive Officer, after a full job evaluation of all positions, including quality assessors and administration staff nationally. Salaries have been aligned with market rates, based on competency skills and levels, and job descriptions. Three levels of competency have been established for quality assessors, starting with initial employment as a trainee, then an assessor competency level 1, competency level 2 and competency level 3.
(vi) The assessment cycle is based on the anniversary of the employee's commencement with the Agency.

(b) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-089

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: STRUCTURE OF AGED CARE SYSTEM

Written Question on Notice

Senator Forshaw asked:

Can you provide data outlining the structure of the aged care industry, that is, the proportion of for-profit/private providers compared with not-for-profit/voluntary providers for 1997, 1998, 1999, 2000, 2001, 2002 and 2003?

Answer:

The table below shows the structure of the residential aged care sector as indicated by the proportion of approved providers in the private and other sectors respectively at 30 June in each year, 1999 to 2003.

Prior to the 1997 Aged Care Reforms, separate systems were used to manage payments and other data for hostels and for nursing homes. In 1997 only part of the data from the former systems was merged to create an integrated system. For technical reasons, it would be complex and costly to extract data for financial years earlier than 1998-99.

Structure of residential aged care sector as shown by proportion of approved providers, as at 30 June, 1999 to 2003

	1999	2000	2001	2002	2003
Private	34.7%	34.5%	34.4%	34.5%	35.0%
Not-for-profit	65.3%	65.5%	65.6%	65.5%	65.0%

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-090

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE ROUND ALLOCATIONS

Written Question on Notice

Senator Forshaw asked:

Can you provide the following data for each aged care round allocation for 1997, 1998, 1999, 2000, 2001, 2002 and 2003:

(a) High care residential allocations by
- not-for-profit sector compared with for-profit sector
- existing facilities which will build extensions compared with stand-alone facilities (that need to be built from scratch)

(b) Low care residential allocations by
- not-for-profit sector compared with for-profit sector
- existing facilities which will build extensions compared with stand-alone facilities (that need to be built from scratch)

Answer:

Allocations for additional aged care places are conducted through a competitive process, with applications rigorously assessed against criteria specified in the *Aged Care Act 1997* and the *Aged Care Principles*. The criteria include the expertise and experience of those who will manage the service, the ability of the applicant to provide the appropriate level of care, the past conduct of a provider of aged care including compliance with responsibilities and obligations, the provision of appropriate care for people with special needs and whether the premises are suitably planned and located.

The Delegate of the Secretary of the Department decides on the allocation of places.

Details of the allocations made in 1999, 2000, 2001, 2002 and 2003, by organisation type, are shown in the attached table.

The collection of information on the nature of any building activity for each application for places would be resource intensive and require the diversion of scarce resources from higher priority activities.

Allocation of places by organisation type: 1999-2003

Year	Care Type	Religious Charitable Community	Private	State and Local Government	**Total**
1999	High care	170	120	4	**294**
	High care %	58%	41%	1%	**100%**
	Low care	895	1162	5	**2062**
	Low care %	43%	56%	1%	**100%**
	Overall %	**45.2%**	**54.4%**	**0.4%**	**100%**

Year	Care Type	Religious Charitable Community	Private	State and Local Government	**Total**
2000	High care	111	161	5	**277**
	High care %	40%	58%	2%	**100%**
	Low care	2530	3908	214	**6652**
	Low care %	38%	59%	3%	**100%**
	Overall %	**38.1%**	**58.7%**	**3.2%**	**100%**
2001	High care	1165	768	88	**2021**
	High care %	58%	38%	4%	**100%**
	Low care	2503	1569	102	**4174**
	Low care %	60%	38%	2%	**100%**
	Overall %	**59.2%**	**37.7%**	**3.1%**	**100%**
2002	High care	819	1065	40	**1924**
	High care %	43%	55%	2%	**100%**
	Low care	1607	1279	67	**2953**
	Low care %	55%	43%	2%	**100%**
	Overall %	**49.7%**	**48.1%**	**2.2%**	**100%**

2003	High care	752	1151	16	**1919**
	High care %	39%	60%	1%	**100%**
	Low care	1412	2063	49	**3524**
	Low care %	40%	58.5%	1.5%	**100%**
	Overall %	**39.7%**	**59.1%**	**1.2%**	**100%**

Note: Data is not available for 1997 and 1998.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-091

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE RESIDENT DEPENDENCY LEVELS

Written Question on Notice

Senator Forshaw asked:

(a) Can we have detailed statistics on people being admitted into aged care facilities for each year since 1997 - for example the number and proportion at each RCS level?

(b) What statistics are available on the change in RCS levels of residents for each year since 1997? For example, is it possible to know:

(i) how many people are upgraded from low care to high care within 6 months

(ii) how many people are upgraded from low care to high care within 12 months of being admitted?

(iii) The number of people upgraded for each year since 1997 in relation to each RCS level?

Answer:

(a) Number of First Time Permanent Admissions by RCS Level

	RCS Category	1998 – 1999	1999 - 2000	2000 – 2001	2001 - 2002	2002 - 2003
High	S1	3,798	4,166	5,060	5,863	6,743
	S2	8,619	8,827	9,245	9,282	10,207
	S3	7,085	6,928	6,531	6,143	6,537
	S4	1,884	1,939	1,866	1,844	2,108
Low	S5	3,511	3,590	4,133	4,885	5,620
	S6	4,059	4,177	4,601	5,001	5,406
	S7	6,227	6,218	6,059	5,759	6,322
	S8	823	757	580	466	472
Total		40,133	39,977	41,179	41,964	46,016

(b)(i) Number of residents that moved from a low RCS category, to a High RCS category, within 6 months of admission

Financial Year	Number of Residents
1998-1999	420
1999-2000	425
2000-2001	517
2001-2002	553
2002-2003	755

(b)(ii) Number of residents that upgraded from a low RCS category, to a High RCS category within 12 months of admission

Financial Year	Number of Residents
1998-1999	Not available
1999-2000	2,371
2000-2001	2,766
2001-2002	3,072
2002-2003	3,644

(b)(iii) Number of people with an upgraded RCS category, by year

Data is not available before 1998-99 year.

1999-2000

	RCS Category Prior to Upgrade							
	S2	S3	S4	S5	S6	S7	S8	Total
Upgraded to S1	7,221	1,299	77	24	2	1	0	8,624
Upgraded to S2		6,755	545	186	55	18	3	7,562
Upgraded to S3			1,920	1,190	419	161	6	3,696
Upgraded to S4				1,314	576	188	4	2,082
Upgraded to S5					2,828	1,280	30	4,138
Upgraded to S6						3,808	95	3,903
Upgraded to S7							1,078	1,078
Total	7,221	8,054	2,542	2,714	3,880	5,456	1,216	31,083

2000-2001

	RCS Category Prior to Upgrade							
	S2	S3	S4	S5	S6	S7	S8	Total
Upgraded to S1	7,645	1,141	70	28	10	5	0	8,899
Upgraded to S2		6,348	503	232	69	34	2	7,188
Upgraded to S3			2,066	1,432	504	223	8	4,233
Upgraded to S4				1,417	633	282	4	2,336
Upgraded to S5					3,418	1,598	32	5,048
Upgraded to S6						4,366	124	4,490
Upgraded to S7							1,010	1,010

Total	7,645	7,489	2,639	3,109	4,634	6,508	1,180	33,204

2001-2002

	RCS Category Prior to Upgrade							
	S2	S3	S4	S5	S6	S7	S8	Total
Upgraded to S1	7,711	1,117	67	29	10	5	0	8,939
Upgraded to S2		5,818	463	229	62	27	3	6,602
Upgraded to S3			1,928	1,475	502	178	4	4,087
Upgraded to S4				1,505	664	224	7	2,400
Upgraded to S5					3,356	1,394	21	4,771
Upgraded to S6						3,959	71	4,030
Upgraded to S7							749	749
Total	7,711	6,935	2,458	3,238	4,594	5,787	855	31,578

2002-2003

	RCS Category Prior to Upgrade							
	S2	S3	S4	S5	S6	S7	S8	Total
Upgraded to S1	8,122	1,079	75	46	26	11	0	9,359
Upgraded to S2		5,411	501	267	90	55	0	6,324
Upgraded to S3			1,970	1,561	592	193	5	4,321
Upgraded to S4				1,642	678	192	6	2,518
Upgraded to S5					3,683	1,332	19	5,034
Upgraded to S6						3,835	59	3,894
Upgraded to S7							581	581
Total	8,122	6,490	2,546	3,516	5,069	5,618	670	32,031

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-092

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: CAPITAL GRANTS

Written Question on Notice

Senator Forshaw asked:

Can you provide the following data for each Aged Care Round allocation for each year since 1997:
Capital grants to

(a) Not-for-profit sector compared with for-profit sector

(b) Existing facilities which will build extensions compared with stand-alone facilities (that need to be built from scratch)

Answer:

(a) Details of capital grant allocations made in 1998, 1999, 2000, 2001, 2002 and 2003, by not-for-profit and for-profit are shown in the table below.

	Grants made to not-for-profit providers		Grants made to for-profit providers	
Year of allocation	Number of Grants	Amount of Grants	Number of Grants	Amount of Grants
*1998	88	$19,399,300	15	$2,467,200
1999	96	$20,752,500	10	$1,114,000
2000	107	$38,079,300	5	$751,000
2001	73	$25,671,500	1	$12,500
2002	72	$33,938,500	4	$1,734,500
2003	44	$36,978,000	1	$810,000

**Grants in relation to 1997 and 1998 were allocated in 1998.*

(b) The information requested is not available to the Department.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-093

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: COMMUNITY CARE REVIEW

Written question on Notice.

Senator Forshaw asked:

What progress has been made since publication of 'A New Strategy for Community Care Consultation Paper'? Is there a more detailed paper available yet? If not, when will that be available?

Answer:

The National Reference Group for the Review of Community Care was established in June 2003 to provide advice on the Consultation Paper and a draft working paper canvassing implementation issues. The Group comprises a broad cross-section of leading members of the community care and disability support sectors, and met three times during 2003. The Group expressed support to the Minister for Ageing in January 2004 for the integrated approach to community care through adoption of the Framework and principles outlined in the Consultation Paper.

The Home and Community Care Specific Purpose Payment Agreement is due for review in 2004. It is expected that the review of this Agreement will provide the context for further discussions with the States and Territories on the implementation of the Framework.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-094

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RESIDENTIAL AGED CARE ACCOMMODATION BONDS

Written Question on Notice

Senator Forshaw asked:

(a) What progress has been made between the Department and the aged care sector to improve the prudential arrangements for accommodation bonds?

(b) If a person sells their home to pay an accommodation bond, are the funds given to the aged care facility as a bond, considered an asset by Centrelink.

Answer:

(a) The Pricing Review has examined a range of issues including prudential arrangements for accommodation bonds. The Government has received a summary report from the Reviewer and is giving it careful consideration.

(b) Yes. However, the allowable amount of assets for a non-home owner is $108,000 more than it is for a home owner.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-095

OUTCOME 3 ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PINEVILLE PRIVATE NURSING HOME, VICTORIA

Written question on Notice

Senator Forshaw asked:

(a) Can you provide information about the current accreditation status of Pineville Nursing Home in Geelong, Victoria?

(b) Has it failed any Accreditation Standards?

(c) Have sanctions been placed on this facility?

(d) Is the facility closing down?

Answer:

(a) Pineville Private Nursing Home closed on 23 January 2004.

(b) See (a)

(c) See (a)

(d) See (a)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-096

OUTCOME 3 ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ACCREDITATION AND SAFETY OF RESIDENTS

Written question on Notice

Senator Forshaw asked:

What Accreditation Standards exist to protect the safety of residents eg to prevent residents of aged care facilities from jumping or falling out of windows?

Answer:

Standard 4. Physical environment and safe systems.

Elements of other standards such as;

2.13 Behavioural Management, which states "the needs of residents with challenging behaviours are managed effectively" are also relevant.

The standards do not prescribe how the expected outcomes should be met.

Aged care homes are also required, by the Department of Health and Ageing, to have passed building certification and comply with the Building Code of Australia (BCA96). The BCA contains technical provisions for the design and construction of buildings and other structures, covering such matters as structure, fire resistance, access and egress, fire-fighting equipment, mechanical ventilation, lift installations, and certain aspects of health and amenity.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-097

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: HOGAN REVIEW

Written Question on Notice

Senator Forshaw asked:

(a) Has the Government asked or instructed Professor Hogan to revise his 'interim report' which the Minister claimed to have on 12 February 2004?

(b) Is the Government currently negotiating the content of the Review with Professor Hogan?

(c) Can the Department provide a copy of the interim report to the Community Affairs Committee?

Answer:

(a) The Department has no information which would indicate that the Government has asked or instructed Professor Hogan to revise his 'interim report'.

(b) Professor Hogan submitted his final report to the Government on 5 April 2004.

(c) A copy of the document, *Summary of the Report of the Review of Pricing Arrangements in Residential Aged Care*, is attached.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-123

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE LENGTH OF STAY

Written Question on Notice

Senator Forshaw asked:

Are you able to provide statistics (the number and proportion of residents) on the length of stay from entry to death in aged care facilities for each year since 1990? (For example X% of residents die within X weeks.)

Answer:

The following table provides data relating to the total length of a discharged resident's stay for permanent care in all facilities.

There is no clear cut pattern in the change over time of length of stay. The total proportion of residents in care for less than 1 month, 6-12 months, 1-2 years or 2-5 years has declined from 1998-99 to 2002-03, while the proportion staying 1-3 months, 3-6 months or more than 5 years has increased over the same period. A similar result applies when only discharges due to death are considered.

The total proportion of persons staying less than 12 months was 35.4% in 1998-99 and 35.6% in 2002-03. Thus the proportion of persons staying 12 months or longer was 64.6% in 1998-99 and 64.4% in 2002-03.

Discharges from permanent care by total length of stay and reason for discharge – as a percentage of all discharges (a)(b)

Length of stay	Discharge Reason	1998-99	1999-00	2000-01	2001-02	2002-03
< 1 month	Death	6.7%	6.5%	6.3%	6.4%	6.5%
	Other	1.3%	1.0%	1.0%	1.0%	1.2%
	subtotal	8.0%	7.5%	7.4%	7.4%	7.7%
1-3 months	Death	7.4%	7.3%	7.4%	7.4%	7.9%
	Other	1.3%	1.2%	1.2%	1.2%	1.2%
	subtotal	8.7%	8.6%	8.6%	8.7%	9.1%
3-6 months	Death	6.8%	6.7%	6.6%	6.8%	7.2%
	Other	1.1%	1.1%	1.1%	1.0%	1.1%
	subtotal	7.8%	7.9%	7.7%	7.7%	8.3%
6-12 months	Death	9.7%	9.0%	9.2%	9.4%	9.4%
	Other	1.1%	1.1%	1.1%	1.1%	1.2%
	subtotal	10.8%	10.1%	10.4%	10.5%	10.5%
1-2 years	Death	16.2%	13.8%	13.4%	13.5%	13.7%
	Other	1.4%	1.4%	1.3%	1.1%	1.1%
	subtotal	17.5%	15.2%	14.7%	14.6%	14.8%
2-5 years	Death	26.4%	29.1%	27.0%	25.6%	24.4%
	Other	1.7%	1.6%	1.7%	1.5%	1.5%
	subtotal	28.2%	30.7%	28.8%	27.1%	25.9%
5+ years	Death	18.0%	19.2%	21.5%	22.9%	22.8%
	Other	0.9%	0.9%	1.0%	1.0%	0.9%
	subtotal	18.9%	20.1%	22.5%	23.9%	23.7%
Total		100.0%	100.0%	100.0%	100.0%	100.0%

(a) The tables exclude any period of respite care. Some of the discharges are for reasons other than death; it is possible that these residents may subsequently re-enter care.

(b) The earliest financial year for which there are useable data on length of stay is 1998-99. Prior to the 1997 Aged Care Reforms, separate systems were used to manage payments and other data for hostels and for nursing homes. For technical reasons, it would be complex and costly to extract data for financial years earlier than 1998-99.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-207

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: SALVATION ARMY

Hansard Page: CA 49

Senator Forshaw asked:

What was the nature of the correspondence from The Salvation Army and specifically, was it an indication of an intention to divest these properties or these facilities?

Answer:

In a letter dated 22 July 2003, the Australia Southern Territory of The Salvation Army advised the Department, on a strictly confidential basis, that it was looking to negotiate a sale of its residential aged care services to another approved provider.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-208

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: AGED CARE STATISTICS

Hansard Page: CA51

Senator Forshaw asked:

(a) What was the basis of the Department's calculations?

(b) Can the statistics that the Department used to base the allocations of aged care places for the 2003 allocations round…be supplied?

(c) Can you provide the aged care stock take figures of provisional and actual places as at the end of 2003?

Answer:

(a) The population projections used by the Department in 2003 for Residential Aged Care planning and allocation purposes were small area projections developed by the Australian Bureau of Statistics (*Population Projections by SLA (ASGC 1996) 1999 – 2019 Commonwealth Department of Health Aged Care*). The 2003 Level 1 Allocation Round used these projections of the population aged 70 years or over, in conjunction with other variables, such as existing Provisional Allocations, to determine future place allocations.

(b) The estimates of the 70 plus population used are contained in the following table.

Estimated population aged 70 years or over							
State	2002	2003	2004	2005	2006	2007	2008
NSW	619,851	629,689	638,873	647,850	658,267	670,366	682,601
Vic	456,493	465,256	473,997	481,531	490,030	498,909	508,504
Qld	301,738	307,263	312,768	318,759	325,415	333,474	341,820
WA	148,235	151,666	154,983	158,690	162,503	166,755	171,614
SA	163,975	166,241	168,402	170,141	171,951	174,296	176,585
Tas	46,766	47,323	47,910	48,370	48,830	49,536	50,343
NT	4,140	4,189	4,222	4,307	4,488	4,611	4,779
ACT	18,875	19,459	20,081	20,733	21,345	21,999	22,765
Aust	1,760,073	1,791,086	1,821,236	1,850,381	1,882,829	1,919,946	1,959,011

Source: Population Projections by SLA 1999 – 2019, Department of Health and Aged Care (ASGC 1996)

(c) As at the 31 December 2003 stocktake, there were 181,711 operational aged care places and 198,498 allocated places, which include provisional places and places that are off-line pending rebuilding. The time it has taken for provisional places to become operational is greatly influenced by State/Territory and local government planning processes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-209

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: HOGAN REPORT

Hansard Page: CA55

Senator Forshaw asked:

(a) Was the Professor asked to provide you with some indication of his progress?

(b) Who asked him to provide that?

Answer:

(a) and (b)

Professor Hogan wrote to the Minister asking for an extension of the completion date for the Review. As is normal practice, the Minister asked him for an indication of his progress.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-210

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: TOTAL AGED CARE PLACES BY STATE AND TERRITORY - 1994 TO 2003

Hansard Page: CA58

Senator Knowles asked:

Would it be possible to obtain a list of places for the last 10 years in the same format?

(See Mr Mersiades answer CA59)
That stocktake arrangement was instituted only a couple of years ago, but we can show the growth in places over the years and we can give you that in that format for the years that we have been producing it.

Answer:

The following tables are sourced from stocktakes of allocated and operational aged care places undertaken by the Department of Health and Ageing since 2001, and from Department of Health and Ageing data on operational places since 1994.

The data on operational places show an increase in the provision ratio from 93.4 at 30 June 1994 to 99.7 by 30 June 2003.

Data on allocated places prior to 2001 is not readily available.

Ratios of allocated and operational aged care places express the number of places for 1,000 persons aged 70 or over.

a) Allocated places and ratios:

Total Allocated Places by State / Territory
30 June 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	30,730	28,407	**59,137**	9,639	**68,776**
VIC	19,763	23,756	**43,519**	7,172	**50,691**
QLD	13,651	15,561	**29,212**	4,496	**33,708**
WA	6,679	8,095	**14,774**	2,381	**17,155**
SA	7,874	8,123	**15,997**	2,631	**18,628**
TAS	2,271	2,174	**4,445**	810	**5,255**
ACT	757	969	**1,726**	362	**2,088**
NT	347	243	**590**	505	**1,095**
Australia	**82,072**	**87,328**	**169,400**	**27,996**	**197,396**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Allocated Ratio by State / Territory

30 June 2003

State / Territory	High care	*Low care*	*Total* Residential	Community Aged Care Packages	TOTAL PLACES
NSW	48.8	45.1	**93.9**	15.3	**109.2**
VIC	42.5	51.1	**93.5**	15.4	**109.0**
QLD	44.4	50.6	**95.1**	14.6	**109.7**
WA	44.0	53.4	**97.4**	15.7	**113.1**
SA	47.4	48.9	**96.2**	15.8	**112.1**
TAS	48.0	45.9	**93.9**	17.1	**111.0**
ACT	38.9	49.8	**88.7**	18.6	**107.3**
NT	82.8	58.0	**140.8**	120.6	**261.4**
Australia	**45.8**	**48.8**	**94.6**	**15.6**	**110.2**

Total Allocated Places by State / Territory

30 June 2002

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	30,440	27,080	**57,520**	9,290	**66,810**
VIC	19,097	23,086	**42,183**	6,767	**48,950**
QLD	13,100	15,117	**28,217**	4,353	**32,570**
WA	6,259	7,719	**13,978**	2,269	**16,247**
SA	7,554	7,907	**15,461**	2,546	**18,007**
TAS	2,239	2,132	**4,371**	746	**5,117**
ACT	715	942	**1,657**	352	**2,009**
NT	327	236	**563**	447	**1,010**
Australia	**79,731**	**84,219**	**163,950**	**26,770**	**190,720**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Allocated Ratio by State / Territory

30 June 2002

State / Territory	High care	*Low care*	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	49.1	43.7	**92.8**	15.0	**107.8**
VIC	41.8	50.6	**92.4**	14.8	**107.2**
QLD	43.4	50.1	**93.5**	14.4	**107.9**
WA	42.2	52.1	**94.3**	15.3	**109.6**
SA	46.1	48.2	**94.3**	15.5	**109.8**
TAS	47.9	45.6	**93.5**	16.0	**109.4**
ACT	37.9	49.9	**87.8**	18.6	**106.4**
NT	79.0	57.0	**136.0**	108.0	**244.0**
Australia	**45.0**	**48.0**	**93.0**	**15.2**	**108.4**

Total Allocated Places by State / Territory

30 June 2001

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	30,159	25,536	**55,695**	8,708	**64,403**
VIC	18,360	21,906	**40,266**	6,287	**46,553**
QLD	12,569	14,635	**27,204**	4,077	**31,281**
WA	6,022	7,265	**13,287**	2,125	**15,411**
SA	7,225	7,579	**14,804**	2,352	**17,156**
TAS	2,228	2,024	**4,252**	688	**4,940**
ACT	654	922	**1,576**	346	**1,922**
NT	291	261	**552**	331	**882**
Australia	**77,508**	**80,127**	**157,635**	**24,913**	**182,548**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Allocated Ratio by State / Territory

30 June 2001

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	49.5	41.9	**91.4**	14.3	**105.7**
VIC	41.0	48.9	**90.0**	14.0	**104.0**
QLD	42.5	49.4	**91.9**	13.8	**105.7**
WA	41.6	50.2	**91.8**	14.7	**106.4**
SA	44.7	46.9	**91.5**	14.5	**106.1**
TAS	48.2	43.8	**92.1**	14.9	**107.0**
ACT	35.8	50.4	**86.2**	18.9	**105.2**
NT	71.3	63.8	**135.2**	81.0	**216.2**
Australia	**44.9**	**46.4**	**91.2**	**14.4**	**105.7**

b) Operational places and ratios:

Total Operational Places by State / Territory

30 June 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	28,893	23,377	**52,270**	9,601	**61,871**
VIC	17,705	20,111	**37,816**	7,112	**44,928**
QLD	12,529	14,564	**27,093**	4,489	**31,582**
WA	5,963	6,968	**12,931**	2,375	**15,306**
SA	7,388	7,198	**14,586**	2,611	**17,197**
TAS	2,234	1,834	**4,068**	808	**4,876**
ACT	635	910	**1,545**	362	**1,907**
NT	284	193	**477**	492	**969**
Australia	**75,631**	**75,155**	**150,786**	**27,850**	**178,636**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Operational Ratio by State / Territory

30 June 2003

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	45.9	37.1	**83.0**	15.2	**98.3**
VIC	38.1	43.2	**81.3**	15.3	**96.6**
QLD	40.8	47.4	**88.2**	14.6	**102.8**
WA	39.3	45.9	**85.3**	15.7	**100.9**
SA	44.4	43.3	**87.7**	15.7	**103.4**
TAS	47.2	38.8	**86.0**	17.1	**103.0**
ACT	32.6	46.8	**79.4**	18.6	**98.0**
NT	67.8	46.1	**113.9**	117.5	**231.3**
Australia	**42.2**	**42.0**	**84.2**	**15.6**	**99.7**

Total Operational Places by State / Territory

30 June 2002

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	28,617	22,500	**51,117**	9,237	**60,354**
VIC	17,432	18,612	**36,044**	6,576	**42,620**
QLD	12,513	14,024	**26,537**	4,339	**30,876**
WA	5,883	6,658	**12,541**	2,255	**14,796**
SA	7,138	6,732	**13,870**	2,460	**16,330**
TAS	2,200	1,702	**3,902**	739	**4,641**
ACT	635	890	**1,525**	352	**1,877**
NT	278	188	**466**	445	**911**
Australia	**74,696**	**71,306**	**146,002**	**26,403**	**172,405**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Operational Ratio by State / Territory

30 June 2002

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	46.2	36.3	**82.5**	14.9	**97.4**
VIC	38.2	40.8	**79.0**	14.4	**93.4**
QLD	41.5	46.5	**87.9**	14.4	**102.3**
WA	39.7	44.9	**84.6**	15.2	**99.8**
SA	43.5	41.1	**84.6**	15.0	**99.6**
TAS	47.0	36.4	**83.4**	15.8	**99.2**
ACT	33.6	47.2	**80.8**	18.6	**99.4**
NT	67.1	45.4	**112.6**	107.5	**220.0**
Australia	**42.4**	**40.5**	**83.0**	**15.0**	**98.0**

Total Operational Places by State / Territory

30 June 2001

State / Territory	High care	Low care	Total *Residential*	Community Aged Care Packages	TOTAL PLACES
NSW	28,563	21,773	**50,336**	8,636	**58,972**
VIC	17,257	17,851	**35,108**	6,254	**41,362**
QLD	12,353	13,643	**25,996**	4,030	**30,026**
WA	5,873	6,543	**12,416**	2,110	**14,525**
SA	7,040	6,728	**13,768**	2,337	**16,105**
TAS	2,179	1,668	**3,847**	674	**4,521**
ACT	635	875	**1,510**	336	**1,846**
NT	251	197	**448**	317	**765**
Australia	**74,151**	**69,278**	**143,429**	**24,694**	**168,122**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Operational Ratio by State / Territory

30 June 2001

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	46.9	35.7	**82.6**	14.2	**96.8**
VIC	38.6	39.9	**78.4**	14.0	**92.4**
QLD	41.7	46.1	**87.8**	13.6	**101.4**
WA	40.6	45.2	**85.7**	14.6	**100.3**
SA	43.5	41.6	**85.1**	14.5	**99.6**
TAS	47.2	36.1	**83.3**	14.6	**97.9**
ACT	34.7	47.9	**82.6**	18.4	**101.0**
NT	61.5	48.3	**109.8**	77.7	**187.5**
Australia	**42.9**	**40.1**	**83.0**	**14.3**	**97.3**

Total Operational Places by State / Territory

30 June 2000

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	28,855	21,325	**50,180**	6,367	**56,547**
VIC	17,134	17,827	**34,961**	4,517	**39,478**
QLD	12,276	13,452	**25,728**	3,163	**28,891**
WA	5,866	6,241	**12,107**	1,571	**13,678**
SA	7,311	6,404	**13,715**	1,636	**15,351**
TAS	2,148	1,669	**3,817**	584	**4,401**
ACT	623	860	**1,483**	308	**1,791**
NT	241	185	**426**	193	**619**
Australia	**74,454**	**67,963**	**142,417**	**18,339**	**160,756**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Operational Ratio by State / Territory

30 June 2000

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	48.5	35.8	**84.3**	10.7	**95.0**
VIC	39.3	40.9	**80.3**	10.4	**90.7**
QLD	42.5	46.6	**89.1**	11.0	**100.1**
WA	41.8	44.5	**86.2**	11.2	**97.4**
SA	46.1	40.4	**86.5**	10.3	**96.8**
TAS	47.3	36.8	**84.1**	12.9	**97.0**
ACT	35.3	48.8	**84.1**	17.5	**101.5**
NT	61.1	46.9	**108.0**	49.0	**157.0**
Australia	**44.2**	**40.3**	**84.5**	**10.9**	**95.4**

Total Operational Places by State / Territory

30 June 1999

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	28,991	21,024	**50,015**	4,728	**54,743**
VIC	17,477	17,279	**34,756**	3,323	**38,079**
QLD	12,404	13,030	**25,434**	2,456	**27,890**
WA	5,939	6,131	**12,070**	1,206	**13,276**
SA	7,222	6,447	**13,669**	1,276	**14,945**
TAS	2,136	1,642	**3,778**	450	**4,228**
ACT	614	812	**1,426**	284	**1,710**
NT	229	172	**401**	171	**572**
Australia	**75,012**	**66,537**	**141,549**	**13,894**	**155,443**

Notes:
These figures include flexible care places: Extended Aged Care at Home, Multipurpose Services, and places allocated under the National Aboriginal and Torres Strait Islander Aged Care Strategy. Flexible care places are attributed as high care, low care and Community Aged Care Packages.

Total Operational Ratio by State / Territory

30 June 1999

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	49.9	36.2	**86.1**	8.1	**94.2**
VIC	41.2	40.8	**82.0**	7.8	**89.9**
QLD	44.1	46.4	**90.5**	8.7	**99.2**
WA	43.6	45.0	**88.5**	8.8	**97.4**
SA	46.6	41.6	**88.1**	8.2	**96.3**
TAS	47.9	36.8	**84.6**	10.1	**94.7**
ACT	36.0	47.6	**83.6**	16.6	**100.2**
NT	59.1	44.2	**103.4**	44.0	**147.3**
Australia	**45.7**	**40.5**	**86.1**	**8.5**	**94.6**

Total Operational Places by State / Territory

30 June 1998

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	29,048	20,408	**49,456**	3,493	**52,949**
VIC	17,697	16,885	**34,582**	2,334	**36,916**
QLD	12,157	12,792	**24,949**	1,723	**26,672**
WA	5,870	5,939	**11,809**	822	**12,631**
SA	6,969	6,449	**13,418**	989	**14,407**
TAS	2,168	1,562	**3,730**	378	**4,108**
ACT	604	816	**1,420**	169	**1,589**
NT	211	149	**360**	106	**466**
Australia	**74,724**	**65,000**	**139,724**	**10,014**	**149,738**

Total Operational Ratio by State / Territory

30 June 1998

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	51.2	36.0	**87.2**	6.2	**93.3**
VIC	42.8	40.8	**83.7**	5.6	**89.3**
QLD	44.6	46.9	**91.5**	6.3	**97.8**
WA	44.4	44.9	**89.3**	6.2	**95.5**
SA	45.8	42.4	**88.3**	6.5	**94.8**
TAS	49.7	35.8	**85.4**	8.7	**94.1**
ACT	37.0	50.1	**87.1**	10.4	**97.5**
NT	57.1	40.3	**97.4**	28.7	**126.1**
Australia	**46.7**	**40.6**	**87.2**	**6.3**	**93.5**

Total Operational Places by State / Territory

30 June 1997

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	28,889	20,368	**49,257**	2,319	**51,576**
VIC	17,502	16,568	**34,070**	1,543	**35,613**
QLD	12,189	12,848	**25,037**	1,125	**26,162**
WA	5,833	5,924	**11,757**	612	**12,369**
SA	6,928	6,490	**13,418**	647	**14,065**
TAS	2,146	1,589	**3,735**	262	**3,997**
ACT	519	829	**1,348**	87	**1,435**
NT	210	155	**365**	45	**410**
Australia	**74,216**	**64,771**	**138,987**	**6,640**	**145,627**

Total Operational Ratio by State / Territory

30 June 1997

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	52.2	36.8	**89.0**	4.2	**93.2**
VIC	43.5	41.2	**84.6**	3.8	**88.5**
QLD	46.2	48.7	**94.9**	4.3	**99.2**
WA	45.4	46.1	**91.5**	4.8	**96.3**
SA	46.8	43.8	**90.6**	4.4	**94.9**
TAS	50.1	37.1	**87.3**	6.1	**93.4**
ACT	33.6	53.7	**87.3**	5.6	**92.9**
NT	59.3	43.8	**103.1**	12.7	**115.8**
Australia	**47.6**	**41.6**	**89.2**	**4.3**	**93.5**

Total Operational Places by State / Territory

30 June 1996

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	29,291	20,042	**49,333**	1,520	**50,853**
VIC	17,197	15,641	**32,838**	1,084	**33,922**
QLD	12,282	12,438	**24,720**	731	**25,451**
WA	5,762	5,638	**11,400**	398	**11,798**
SA	6,981	6,326	**13,307**	468	**13,775**
TAS	2,138	1,487	**3,625**	160	**3,785**
ACT	519	764	**1,283**	47	**1,330**
NT	210	135	**345**	33	**378**
Australia	**74,380**	**62,471**	**136,851**	**4,441**	**141,292**

Total Operational Ratio by State / Territory

30 June 1996

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	54.6	37.3	**91.9**	2.8	**94.7**
VIC	44.0	40.0	**83.9**	2.8	**86.7**
QLD	48.2	48.8	**96.9**	2.9	**99.8**
WA	46.5	45.5	**91.9**	3.2	**95.1**
SA	48.5	43.9	**92.4**	3.3	**95.7**
TAS	51.1	35.6	**86.7**	3.8	**90.5**
ACT	35.1	51.7	**86.9**	3.2	**90.1**
NT	62.9	40.5	**103.4**	9.9	**113.3**
Australia	**49.2**	**41.3**	**90.6**	**2.9**	**93.5**

Total Operational Places by State / Territory

30 June 1995

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	29,392	19,358	**48,750**	834	**49,584**
VIC	17,001	14,827	**31,828**	640	**32,468**
QLD	12,385	12,028	**24,413**	443	**24,856**
WA	6,130	5,338	**11,468**	210	**11,678**
SA	6,938	6,223	**13,161**	285	**13,446**
TAS	2,133	1,455	**3,588**	98	**3,686**
ACT	519	763	**1,282**	25	**1,307**
NT	192	128	**320**	7	**327**
Australia	**74,690**	**60,120**	**134,810**	**2,542**	**137,352**

Total Operational Ratio by State / Territory

30 June 1995

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	56.6	37.3	**93.9**	1.6	**95.5**
VIC	45.3	39.5	**84.8**	1.7	**86.5**
QLD	49.5	48.1	**97.6**	1.8	**99.4**
WA	50.8	44.2	**95.0**	1.7	**96.7**
SA	49.8	44.7	**94.5**	2.0	**96.6**
TAS	52.5	35.8	**88.3**	2.4	**90.7**
ACT	36.9	54.3	**91.2**	1.8	**93.0**
NT	61.7	41.1	**102.8**	2.2	**105.0**
Australia	**51.1**	**41.1**	**92.2**	**1.7**	**93.9**

Total Operational Places by State / Territory

30 June 1994

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	29,174	18,408	**47,582**	291	**47,873**
VIC	17,082	13,834	**30,916**	313	**31,229**
QLD	12,224	11,404	**23,628**	253	**23,881**
WA	6,101	5,192	**11,293**	81	**11,374**
SA	6,812	5,960	**12,772**	224	**12,996**
TAS	2,094	1,338	**3,432**	43	**3,475**
ACT	557	603	**1,160**	20	**1,180**
NT	192	128	**320**	2	**322**
Australia	**74,236**	**56,867**	**131,103**	**1,227**	**132,330**

Total Operational Ratio by State / Territory

30 June 1994

State / Territory	High care	Low care	Total Residential	Community Aged Care Packages	TOTAL PLACES
NSW	57.9	36.5	**94.4**	0.6	**95.0**
VIC	46.8	37.9	**84.7**	0.9	**85.6**
QLD	50.9	47.5	**98.4**	1.1	**99.5**
WA	52.4	44.6	**97.0**	0.7	**97.7**
SA	50.3	44.0	**94.3**	1.7	**96.0**
TAS	52.5	33.6	**86.1**	1.1	**87.2**
ACT	42.0	45.5	**87.4**	1.5	**88.9**
NT	66.6	44.4	**111.0**	0.7	**111.7**
Australia	**52.4**	**40.1**	**92.5**	**0.9**	**93.4**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-211

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RCS REVIEWS

Hansard Page: CA 59

Senator Forshaw asked:

The cost to the department to undertake the RCS reviews in 2003-04 was $7.6 million. Could you provide a breakdown of how you arrived at the total of $7.6 million?

Answer:

The RCS Review Program employed 64.8 Full Time Equivalent officers in 2003-04. The standard cost to the Department of employing each officer is $118,000 pa. This includes an average direct salary of $60,000 and all Departmental overheads relating to the employment of personnel. The overheads include superannuation, leave, workers' compensation, accommodation, information technology, corporate support and general administrative items.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-212

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RIVERSIDE NURSING HOME- CONFIDENTIAL PATIENT RECORDS

Hansard Page: CA 63/64

Senator Forshaw asked:

Can the Department check that the records have been removed by the council and stored somewhere appropriate?

Answer:

On 5 December 2003, the Department was advised by officers of the Kingston City Council that they were in contact with the developer of the site who confirmed that the building was secure and that there were no medications or documentation left on the site. The Council officers also indicated that some documents had been provided to them for safe keeping.

Riverside Nursing Care Pty Ltd is no longer an Approved Provider and therefore no longer subject to the jurisdictions of the *Aged Care Act 1997*. At the date of closure Voluntary Administrators had been appointed to the home.

Under division 89 of the *Aged Care Act 1997,* former Approved Providers are required to retain records for three years from the date they ceased to provide aged care. At the expiry of that period, it is expected that Approved Providers will dispose of confidential records in accordance with requirements of National Privacy Principle 4 under the Privacy Act 1998 (Commonwealth).

When the residents were relocated, the service was left secure and in the hands of a professional security firm engaged by the Department following consultation with the Voluntary Administrator.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-213

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: RSL VETERANS' RETIREMENT VILLAGE IN NARRABEEN

Hansard Page: CA 67

Senator Forshaw asked:

Is the Department aware of other concerns that have been raised about other conditions at this facility, particularly in regard to food contamination?

What has the Department been made aware of?

Answer:

These matters concern the affairs of an Approved Provider, and as such are protected information under Section 86-2 of *the Aged Care Act 1997(the Act).*

The Department and the Aged Care Standards and Accreditation Agency monitor aged care homes, and follow up on any matters raised which may relate to a breach of an Approved Provider's responsibilities under the Act.

The Aged Care Complaints Resolution Scheme has been established to assist residents, their family and friends to resolve complaints about the care and services provided in Australian Government-funded aged care homes. Specific information should be lodged with the Scheme on 1800 550 552 (freecall) so that it can be dealt with appropriately.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-214

OUTCOME 3: Enhanced Quality of Life for Older Australians

Topic: ANGLICAN CHURCH - SALE OF FACILITIES

Hansard Page: CA 67

Senator Forshaw asked:

(a) What has happened with the sale of the facilities in Wattle Road in Hawthorn and Kangerong Road in Box Hill?

(b) When were they sold, who purchased the home, who is the new provider and what is being done to ensure the continued care of the residents.

(c) Can you also clarify if they have been sold off, what has happened to the residents, where have they been transferred to?

Answer:

(a) The homes referred to are St Anne's Hostel and St Anne's Nursing Home in Wattle Road, Hawthorn, and Carinya Nursing Home in Kangerong Road, Box Hill. In 2002, the approved provider of these homes, Anglican Aged Care Services Group, decided to close the homes by the end of April 2003. Carinya Nursing Home closed on 11 March 2003, St Anne's Hostel closed on 20 March 2003 and St Anne's Nursing Home closed on 31 May 2003.

(b) The homes were closed, not sold. There is therefore not a new provider.

(c) The provider employed a dedicated Resident Support/Liaison Officer to assist residents to identify and move to a home of their choice. Residents from St Anne's and Carinya were given priority of access to any other home operated by the approved provider. The homes did not close until all residents were relocated to a home of their choice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-198

OUTCOME 3 ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: Chelsea Private Nursing Home

Hansard Page: CA59

Senator Forshaw asked:

This home was previously audited in April 2000. Was there particular concern raised about residents unfortunately wandering the units and indeed that some residents had complained that other residents had entered their rooms and interfered with what they were doing? Was that issue raised and was it reflected in the report?

Answer:

The review audit report dated 18 May 2000 reported six residents wandering the units over the two days of the audit. This report also states three residents commented to the team that wandering residents entered their rooms and interfered with their activities on occasions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-199

OUTCOME 3 ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: Chelsea Private Nursing Home

Hansard Page: CA62

Senator Forshaw asked:

Can you tell me if any of the inspectors who undertook these audits were the nominated choices of the home?

Answer:

Neither of the assessment team members was nominated by the approved provider for the September accreditation audit.

The audit in November was a review audit. Approved providers cannot nominate members of an assessment team for review audits.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-146

OUTCOME 4: Quality Health Care

Topic: CSL DIAGNOSTIC PRODUCTS AGREEMENT

Written Question on Notice

Senator McLucas asked:

On 18 June 2002, the Chief Medical Officer announced the extension of the Diagnostic Products Agreement with CSL for a further two years:

(a) What is the value of that contract extension?

(b) How much has CSL been paid under the Diagnostic Products Agreement since CSL was privatised?

(c) What process was followed before making the decision to extend the Agreement with CSL?

(d) Was the Minister involved in this process?

Answer :

(a) The value of the contract extension for the two years for which the contract was extended is estimated at $14.8 million.

(b) CSL Limited has been paid $57 million from 1994/95 to 29 February 2004. It is estimated that a further $3 million will be paid by 30 June 2004 under the Diagnostic Products Agreement.

(c) Diagnostic products were covered in the Review of the Australian Blood Banking and Plasma Products Sector, chaired by Sir Ninian Stephen. The Review reported in 2001 and found that available evidence supported retention of the current arrangements (a supply contract between CSL Limited and the Australian Government) for diagnostic products for an interim period pending market adjustments should any potential second domestic supplier enter the market.

(d) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-147

OUTCOME 4: Quality Health Care

Topic: CSL DIAGNOSTIC PRODUCTS AGREEMENT

Written Question on Notice

Senator McLucas asked:

On the same day, 18 June 2002, the then Minister for Health and Ageing, Senator Patterson, issued a media release stating that the Federal Government would consider competition for the supply of diagnostic products.

The media release mentions that an expert committee would be formed to assist and advise the government on testing the market for supply of diagnostic products.

(a) Was that committee formed? If so, who was on the committee?

(b) The Minister stated that the government planned to use a market testing process in relation to the supply of diagnostic products. What market testing process took place?

(c) What has been the result of the market testing process? (ie, will the exclusive arrangement with CSL be opened up to market competition?)

(d) Were CSL involved in the market testing process or consulted about the market testing process?

Answer

(a) Yes. In October 2002 the Department established the Immunohaematology Reference Group.

The Immunohaematology Reference Group comprised representatives from:
The Royal College of Pathologists of Australasia
The Australian Institute of Medical Scientists
Therapeutic Goods Administration
Australian and New Zealand Society of Blood Transfusion Inc.
The National Coalition of Public Pathology
The Australian Red Cross Blood Service
The Australian Association of Pathology Practices Inc.

(b) The Social Research Centre (Victoria) was engaged to conduct a *Survey of Diagnostic Product End Users*. Survey forms were mailed in November and the final report provided to the Department in December 2002. The Immunohaematology Reference Group provided an analysis of the results of the survey and needs of the immunohaematology industry to the Department in June 2003.

(c) No decision has yet been taken on this matter by Health Ministers.

(d) CSL Limited was requested to supply a list of end-users of diagnostic products to whom they supplied products.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-148

OUTCOME 4: Quality Health Care

Topic: CSL DIAGNOSTIC PRODUCTS AGREEMENT

Written Question on Notice

Senator McLucas asked:

Is the Diagnostic Products Agreement that is currently exclusively with CSL subject to the usual competitive tendering guidelines that government agencies must follow?

Answer:

No. In January 1994 when the Diagnostic Products Agreement was signed, CSL Limited was the only supplier of the full range of diagnostic products required by end-users.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-196

OUTCOME 4 QUALITY HEALTH CARE

Topic: MEDI*CONNECT* – PAYMENTS FOR DEVELOPMENT WORK

Hansard Page: CA 118

Senator McLucas asked:

How much have we paid to the Guild, CR Group or in fact anyone else for work related to Medi*Connect* development?

Answer:

The following payments have been made to software vendors for work related to Medi*Connect* development.

Pharmacy Computers Australia P/L	$188,650.00	(Contract Price $407,000.00)
Global Health Ltd.	$125,438.00	(Contract Price $167,640.00)
Phoenix Computer Systems	$268,218.00	(Contract Price $280,280.00)
Health Communications Network	$255,951.06	(Contract Price $263,165.00)

All the above payments relate to the development and implementation of software, and technical support for the Medi*Connect* Field Test.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-184

OUTCOME 5: Rural Health Care

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANT PROGRAM

Hansard Page: CA 111

Senator Stephens asked:

(a) Can you provide details of that expenditure since the 2000-01 budget, the four years of the appropriation?

(b) Can you provide details of the new services that have been funded as well?

Answer:

(a) Details of expenditure since the 2000-01 Budget.

Financial Year 2000-2001	$952,891
Financial Year 2001-2002	$9,613,534
Financial Year 2002-2003	$6,931,117

(b) Attached is a list of all operational services under the Medical Specialist Outreach Assistance Program (MSOAP) as at February 2004. A service is defined as a specialist providing a service to a locality. It is possible therefore for a specialist to provide services to more than one locality and for a locality to receive more than one service.

State	Specialty	Town/ Region
Vic	Drug & Alcohol	Camperdown
Vic	Drug & Alcohol	Hamilton
Vic	Ear, Nose and Throat	Stawell
Vic	General medicine	Apollo Bay
Vic	General medicine	Ararat
Vic	General medicine and geriatrics	Stawell
Vic	Geriatrics/General Medicine	Heywood
Vic	Neurology	Stawell
Vic	Obstetrics and gynaecology	Stawell
Vic	Obstetrics and gynaecology (fertility)	Casterton
Vic	Obstetrics and gynaecology (fertility)	Warrnambool
Vic	Oncology	Ararat
Vic	Ophthalmology	St Arnaud
Vic	Orthopaedics	Horsham
Vic	Orthopaedics	Nhill
Vic	Paediatric Cardiology	Horsham
Vic	Paediatric Endochrinology	Portland
Vic	Paediatrics	Apollo Bay
Vic	Paediatrics	Portland
Vic	Paediarics	Stawell
Vic	Psychiatry	Heywood
Vic	Psychiatry	Horsham
Vic	Psychiatry	Portland
Vic	Rehabilitation	Camperdown
Vic	Rehabilitation	Hamilton
Vic	Renal Medicine	Horsham
Vic	Urology	Camperdown
Vic	Dermatology	Leongatha
Vic	Emergency Medicine	Orbost
Vic	Ear, Nose and Throat	Bairnsdale
Vic	Ear, Nose and Throat	Orbost
Vic	Gastroenterology	Bairnsdale
Vic	Gastroenterology	Sale
Vic	General medicine	Bairnsdale
Vic	General medicine	Lakes Entrance
Vic	General medicine	Yarram
Vic	General surgery	Yarram
Vic	Geriatrics	Lakes Entrance
Vic	Geriatrics	Leongatha
Vic	Geriatrics	Yarram
Vic	GP upskilling - emergency	Leongatha
Vic	Neurology	Leongatha
Vic	Obstetrics and gynaecology	Lakes Entrance
Vic	Paediatric cardiology	Sale
Vic	Paediatric endocrinology	Sale

Vic	Paediatric neurology	Sale
Vic	Paediatric rehabilitation	Sale
Vic	Paediatric rheumatology	Sale
Vic	Paediatric surgery	Bairnsdale
Vic	Paediatric surgery	Sale
Vic	Paediatrics	Bairnsdale
Vic	Paediatrics	Bairnsdale, Aboriginal
Vic	Paediatrics	Lakes Entrance .
Vic	Paediatrics (upskilling)	Leongatha
Vic	Paediatrics	Omeo
Vic	Paediatrics	Orbost
Vic	Paediatrics	Yarram
Vic	Plastic surgery	Leongatha
Vic	Psychiatry	Mallacoota
Vic	Paediatrics	Lakes Entrance
Vic	Renal Medicine	Lakes Entrance
Vic	Renal Medicine	Orbost
Vic	Psychiatry	Bairnsdale
Vic	Rheumatology	Bairnsdale
Vic	Rheumatology (Paediatric)	Sale
Vic	Renal Medicine	Bairnsdale
Vic	Upper GI surgery	Sale
Vic	Urology	Bairnsdale
Vic	Urology (uro-oncology)	Bairnsdale
Vic	Urology	Leongatha
Vic	Urology (upskilling)	Bairnsdale
Vic	ENT	Stawell
Vic	General medicine	Stawell
Vic	General medicine	Ararat
Vic	Geriatrics	Stawell
Vic	Neurology	Stawell
Vic	Ophthalmology	St Arnaud
Vic	Orthopaedics	Nhill
Vic	Orthopaedics	Horsham
Vic	Paediatric cardiology	Horsham
Vic	Paediatric neurology	Horsham
Vic	Paediatrics	Stawell
Vic	Psychiatry	Horsham
Vic	Renal medicine	Horsham
Vic	Anaesthetic Upskilling	Bright
Vic	Anaesthetic Upskilling	Myrtleford
Vic	Anaesthetic Upskilling	Mt Beauty
Vic	Gastroenterology	Alexandra
Vic	General medicine	Alexandra
Vic	General medicine	Cobram
Vic	General medicine	Nathalia
Vic	General surgery	Bright

Vic	Geriatrics	Alexandra
Vic	Geriatrics	Cobram
Vic	Geriatrics	Nathalia
Vic	Geriatrics	Tallangatta
Vic	Gastroenterology	Alexandra
Vic	GP upskilling - palliative care	Hume Region
Vic	Obstetrics and gynaecology	Alexandra
Vic	Obstetrics and gynaecology	Mansfield
Vic	Ophthalmology	Alexandra
Vic	Oral Surgery	Mansfield
Vic	Paediatrics	Bright
Vic	Paediatrics	Mt Beauty
Vic	Paediatrics	Walwa
Vic	Paediatrics	Corryong
Vic	Psychiatry	Bright
Vic	Psychiatry	Yarrawonga
Vic	Surgery	Bright
Vic	Cardiology	Mildura
Vic	Echocardiography	Mildura
Vic	General medicine	Cohuna
Vic	General medicine	Kerang
Vic	General medicine	Ouyen
Vic	General medicine	Robinvale
Vic	General medicine	Swan Hill
Vic	General surgery	Cohuna
Vic	General surgery	Kerang
Vic	Geriatrics/General surgery	Cohuna
Vic	Geriatrics/General surgery	Kerang
Vic	General medicine	Ouyen
Vic	General medicine	Robinvale
Vic	General medicine	Swan Hill
Vic	Upskilling - cardiology	Mildura
Vic	Neurosurgery	Mildura
Vic	Obstetrics and gynaecology	Swan Hill
Vic	Obstetrics and gynaecology	Robinvale
Vic	Obstetrics and gynaecology (fertility)	Swan Hill
Vic	Ophthalmology	Mildura
Vic	Orthopaedic surgery	Kerang
Vic	Paediatric cardiology	Mildura
Vic	Paediatric (upskilling only)	Mildura
Vic	Paediatrics	Robinvale
Vic	Paediatrics	Kerang
Vic	Psychiatry	Kerang
Vic	Psychiatry	Ouyen
Vic	Psychiatry	Swan Hill
Vic	Renal medicine	Mildura
Vic	Retinal ophthalmology	Mildura
Vic	12.5 Advance Specialist Trainee Training Posts	Several Regions

State	Speciality	Town/ Region
NSW	Anaesthetic Upskilling	Kempsey
NSW	Brain Injury Rehab	Coffs Harbour
NSW	Brain Injury Rehab	Port Macquarie
NSW	Cardiology	Broken Hill
NSW	Cardiology	Dubbo
NSW	Cardiology	Wagga Wagga
NSW	Colorectal techniques procedures	Dubbo
NSW	Community Paediatric Outreach	Box Ridge
NSW	Community Paediatric Outreach	Jali
NSW	Community Paediatric Outreach	Mulli Mulli
NSW	Community Paediatric Outreach	Tabulam
NSW	Dermatology	Broken Hill
NSW	Dermatology	Coffs Harbour
NSW	Dermatology	Cooma
NSW	Dermatology	Dubbo
NSW	Dermatology	Grafton
NSW	Dermatology	Griffith
NSW	Dermatology	Orange
NSW	Dermatology	Port Macquarie
NSW	Dermatology	Taree
NSW	Developmental Paediatrics	Broken Hill
NSW	Developmental Paediatrics	Corowa
NSW	Developmental Paediatrics	Culcairn
NSW	Developmental Paediatrics	Holbrook
NSW	Endocrinology	Balranald
NSW	Endocrinology	Bellingen
NSW	Endocrinology	Coffs Harbour
NSW	Endocrinology	Collarenebri
NSW	Endocrinology	Dareton
NSW	Endocrinology	Dorrigo
NSW	Endocrinology	Goodooga
NSW	Endocrinology	Grafton
NSW	Endocrinology	Ivanhoe
NSW	Endocrinology	Kempsey
NSW	Endocrinology	Lightening Ridge
NSW	Endocrinology	Macksville
NSW	Endocrinology	Menindee
NSW	Endocrinology	Port Macquarie
NSW	Endocrinology	Walgett
NSW	Endocrinology	Wilcannia
NSW	Endocrinology (Reg.Diabetes Centre)	Broken Hill
NSW	Fertility Gynaecology	Broken Hill
NSW	Gastroenterology	Tamworth
NSW	General medicine	Menindee
NSW	General medicine	Walgett

NSW	Genetics	Griffith
NSW	Geriatrics	Wagga Wagga
NSW	GP anaesthetic upskilling	Mid North Coast Area
NSW	Head Injury Services	Lismore
NSW	Neurology	Bega
NSW	Neurology	Cooma
NSW	Neurology	Dubbo
NSW	Neurology	Griffith
NSW	Neurology	Gulgong
NSW	Neurology	Kempsey
NSW	Neurology (Parkinsons)	Coffs Harbour
NSW	Neurosurgery (neuroscience)	Lismore
NSW	Obstetrics - High Risk Antenatal	Orange
NSW	Obstetrics and Gynaecology	Young
NSW	Ophthalmology	Griffith
NSW	Optthalmology	Bega
NSW	Orthopaedic	Young
NSW	Orthopaedic Surgery	Griffith
NSW	Orthopaedic Surgery	Leeton
NSW	Orthopaedics	Deniliquin
NSW	Paediatric Endocrinology	Muswellbrook
NSW	Paediatric Endocrinology	Wagga Wagga
NSW	Paediatric Haematology	Wagga Wagga
NSW	Paediatric Neurology	Muswellbrook
NSW	Paediatric Neurology	Wagga Wagga
NSW	Paediatric Surgery	Muswellbrook
NSW	Paediatrics	Bega
NSW	Paediatrics	Bombala
NSW	paediatrics	Brewarrina
NSW	Paediatrics	Dareton
NSW	Palliative Care	Buladelah
NSW	Palliative Care	Coffs Harbour
NSW	Palliative Care	Forster
NSW	Palliative Care	Gloucester
NSW	Palliative Care	Hawks Nest
NSW	Palliative Care	Kempsey
NSW	Palliative Care	Port Macquarie
NSW	Palliative Care	Taree
NSW	Palliative Care	Wagga Wagga
NSW	Palliative Care	Dubbo
NSW	Palliative Care (Brain injury)	Taree
NSW	Physician	Condobolin
NSW	Physician	Lake Cargelligo
NSW	Physician & Neuropsychiatry	Tamworth
NSW	Psychiatry	Bellingen
NSW	Psychiatry	Cowra
NSW	Psychiatry	Lithgow
NSW	Psychiatry	Albury

NSW	Psychiatry	Batemans Bay
NSW	Psychiatry	Coffs Harbour
NSW	Psychiatry	Deniliquin
NSW	Psychiatry	Grafton
NSW	Psychiatry	Griffith
NSW	Psychiatry	Leeton
NSW	Psychiatry	Moruya
NSW	Psychiatry	Muswellbrook
NSW	Psychiatry	Scone
NSW	Psychiatry	Singleton
NSW	Psychiatry	Tumut
NSW	Psychiatry	Wagga Wagga
NSW	Psychiatry Child and Adolescent	Lismore
NSW	Psychiatry Child and Adolescent	Kempsey
NSW	Psychiatry Child and Adolescent	Taree
NSW	Psychogeriatrics	Ballina
NSW	Psychogeriatrics	Bellingen
NSW	Psychogeriatrics	Coffs Harbour
NSW	Psychogeriatrics	Dorrigo
NSW	Psychogeriatrics	Dubbo
NSW	Psychogeriatrics	Forster
NSW	Psychogeriatrics	Kempsey
NSW	Psychogeriatrics	Lismore
NSW	Psychogeriatrics	Macksville
NSW	Psychogeriatrics	Port Macquarie
NSW	Psychogeriatrics	Wagga Wagga
NSW	Rehabilitation - Geriatric	Bega
NSW	Rehabilitation - Geriatric	Eurobodalla
NSW	Rehabilitation - Geriatric	Young
NSW	Respiratory physician	Kempsey
NSW	Respiratory physician	Richmond Valley
NSW	Rheumatology	Coffs Harbour
NSW	Rheumatology	Cooma
NSW	Rheumatology	Moruya
NSW	Rheumatology	Pambula
NSW	Rheumatology	Wagga Wagga
NSW	Sexual Health	Bourke
NSW	Sexual Health	Brewarrina
NSW	Sexual Health	Collarenebri
NSW	Sexual Health	Dareton
NSW	Sexual Health	Goodooga
NSW	Sexual Health	Ivanhoe
NSW	Sexual Health	Lightening Ridge
NSW	Sexual Health	Menindee
NSW	Sexual Health	Walgett
NSW	Sexual Health	Willcannia
NSW	Surgery	Bingara

NSW	Surgery	Corowa
NSW	Surgery	Mungindi
NSW	Surgery	Warialda
NSW	Thoracic Physician (respiratory)	Dubbo
NSW	Urology	Deniliquin
NSW	Vascular surgery	Bega
NSW	Vascular surgery	Orange

State	Speciality	Town/ Region
WA	Physician	Southern Cross
WA	Anaesthetics	Albany
WA	Anaesthetics	Broome
WA	Anaesthetics	Busselton
WA	Anaesthetics	Carnarvon
WA	Anaesthetics	Collie
WA	Anaesthetics	Derby
WA	Anaesthetics	Esperance
WA	Anaesthetics	Geraldton
WA	Anaesthetics	Kalgoorlie
WA	Anaesthetics	Karratha
WA	Anaesthetics	Katanning
WA	Anaesthetics	Kununurra
WA	Anaesthetics	Manjimup
WA	Anaesthetics	Margaret River
WA	Anaesthetics	Merredin
WA	Anaesthetics	Moora
WA	Anaesthetics	Narrogin
WA	Anaesthetics	Northam
WA	Anaesthetics	Port Hedland
WA	Cardiology	Broome
WA	Cardiology	Derby
WA	Cardiology	Fitzroy Crossing
WA	Cardiology	Halls Creek
WA	Cardiology	Kununurra
WA	Cardiology	Narrogin
WA	Cardiology	Wyndham
WA	Cardiology	Moora
WA	Dermatolgy	Albany
WA	Dermatolgy	Carnarvon
WA	Dermatolgy	Geraldton
WA	Dermatology	Merredin
WA	Dermatology	Port Headland
WA	Endocrinology	Geraldton
WA	Endocrinology	Pt Headland
WA	Ear, Nose and Throat	Broome
WA	Ear, Nose and Throat	Cue
WA	Ear, Nose and Throat	Derby
WA	Ear, Nose and Throat	Exmouth
WA	Ear, Nose and Throat	Fitzroy Crossing
WA	Ear, Nose and Throat	Geraldton
WA	Ear, Nose and Throat	Halls Creek
WA	Ear, Nose and Throat	Kalgoorlie
WA	Ear, Nose and Throat	Katanning
WA	Ear, Nose and Throat	Kununurra

WA	Ear, Nose and Throat	Meekatharra
WA	Ear, Nose and Throat	Mt Magnet
WA	Ear, Nose and Throat	Narrogin
WA	Ear, Nose and Throat	Port Headland / Newman
WA	Ear, Nose and Throat	Wiluna
WA	Ear, Nose and Throat	Wyndham
WA	General Medicine	Punmu
WA	General Medicine	Broome
WA	General Medicine	Cotton creek
WA	General Medicine	Derby
WA	General Medicine	Fitzroy Crossing
WA	General Medicine	Halls Creek
WA	General Medicine	Jigalong
WA	General Medicine	Karratha
WA	General Medicine	Kununurra
WA	General Medicine	Marble Bar
WA	General Medicine	Nullagine
WA	General Medicine	Roebourne
WA	General Medicine	Wyndham
WA	General Surgery	Esperance
WA	Genetics	Port Headland
WA	Geriatrics	Geraldton
WA	Gynaecology	Bidyadanga
WA	Gynaecology	Christmas Creek
WA	Gynaecology	Dampier Peninsula (Lombadina)
WA	Gynaecology	Esperance
WA	Gynaecology	Fitzroy Valley
WA	Gynaecology	Gibb River
WA	Gynaecology	Kutjunga (Halls Creek)
WA	Gynaecology	Kutjunga Communities (Balgo)
WA	Gynaecology	Mt Barnett
WA	Gynaecology	Mt Elizabeth
WA	Gynaecology	Noonkanbah
WA	Gynaecology	One Arm Point (Dampier Pen)
WA	Gynecology	Norseman
WA	Gynecology	Wiluna
WA	Nephrology	Port Headland
WA	Obstetrics & Gynaecology	Paraburdoo
WA	Obstetrics	Albany
WA	Obstetrics	Bridgetown
WA	Obstetrics	Broome
WA	Obstetrics	Busselton
WA	Obstetrics	Carnarvon
WA	Obstetrics	Collie
WA	Obstetrics	Derby
WA	Obstetrics	Esperance
WA	Obstetrics	Geraldton

WA	Obstetrics	Kalgoorlie
WA	Obstetrics	Karratha
WA	Obstetrics	Katanning
WA	Obstetrics	Kununurra
WA	Obstetrics	Manjimup
WA	Obstetrics	Margaret River
WA	Obstetrics	Narrogin
WA	Obstetrics	Northam
WA	Obstetrics	Port Headland
WA	Obstetrics & Gynaecology	Laverton
WA	Obstetrics & Gynaecology	Leinster
WA	Obstetrics & Gynaecology	Leonora
WA	Obstetrics and Gynecology	Ngaanyatjarra
WA	Obstetrics and Gynecology	Southern Cross
WA	Obstetrics and Gynecology	Tjuntjuntjarra
WA	oncology	Geraldton
WA	Ophthalmologist	Katanning
WA	Ophthalmology	Carnarvon
WA	Ophthalmology	Cunderdin
WA	Ophthalmology	Geraldton
WA	Ophthalmology	Karratha
WA	Ophthalmology	Karratha
WA	Ophthalmology	Newmam
WA	Ophthalmology	Roebourne
WA	Orthopaedic surgery	Albany
WA	Orthopaedic surgery	Katanning
WA	Orthopaedics	Broome
WA	Orthopaedics	Derby
WA	Orthopaedics	Fitzroy Crossing
WA	Orthopaedics	Halls Creek
WA	Orthopaedics	Kununurra
WA	Orthopaedics	Port Headland
WA	Orthopaedics	Pt Headland
WA	Orthopaedics	Wyndham
WA	Othopaedics	Esperance
WA	Paediatric ENT	Meekatharra
WA	Paediatric Trainee Post	Derby
WA	Paediatrics	Balgo
WA	Paediatrics	Beagle Bay (Dampier Pen)
WA	Paediatrics	Bidyadanga
WA	Paediatrics	Bililuna
WA	Paediatrics	Broome
WA	Paediatrics	Christmas Creek
WA	Paediatrics	Fitzroy Crossing
WA	Paediatrics	Gibb River
WA	Paediatrics	Halls Creek
WA	Paediatrics	Immintji

WA	Paediatrics	Lombadina (Dampier Pen)
WA	Paediatrics	Mt Barnett
WA	Paediatrics	Mt Elizabeth
WA	Paediatrics	Mulan
WA	Paediatrics	Noonkanbah
WA	Paediatrics	One Arm Point (Dampier Pen)
WA	Paediatrics	Yagga Yagga
WA	Paediatrics	Laverton
WA	Paediatrics	Marble Bar
WA	Paediatrics	Punmu
WA	Paediatrics	Busselton
WA	Paediatrics	Cosmo Newberry
WA	Paediatrics	Cotton creek
WA	Paediatrics	Esperance
WA	Paediatrics	Jigalong
WA	Paediatrics	Karratha
WA	Paediatrics	Kunawarritji
WA	Paediatrics	Leonora
WA	Paediatrics	Norseman
WA	Paediatrics	Northam
WA	Paediatrics	Nullagine
WA	Paediatrics	Roebourne
WA	Paediatrics	Southern Cross
WA	Paediatrics	Tjuntjuntjarra
WA	Paediatrics	Warralong
WA	Paediatrics	Yandeyarra
WA	Pain Management	Kalgoorlie
WA	Pain Management	Narrogin
WA	Pain management/ Palliative Care	Northam
WA	Physician	Esperance
WA	Physician	Karratha
WA	Physician	Laverton
WA	Physician	Leonora
WA	Physician	Meekatharra
WA	Physician	Menzies
WA	Physician	Merredin
WA	Physician	Mullewa
WA	Physician	Ngaanyatjarra
WA	Physician	Norseman
WA	Physician	Tjuntjuntjarra
WA	Plastic Surgery	Kalgoorlie
WA	Psychiatry	Merredin
WA	Psychiatry	Moora
WA	Psychiatry	Geraldton
WA	Psychiatry	Jigalong
WA	Psychiatry	Marble Bar

WA	Psychiatry	Newman
WA	Psychiatry	Nullagine
WA	Psychiatry	Tom Price
WA	Psychiatry	Yandeyarra
WA	Respiratory Physician	Narrogin
WA	Rheumatology	Kalgoorlie
WA	Rheumatology	Merredin
WA	Spine Clinic	Kalgoorlie
WA	Surgery	Carnarvon
WA	Surgery	Fitzroy Crossing
WA	Surgery	Halls Creek
WA	Surgery	Wyndham
WA	Uro gynaecology	Geraldton
WA	Urology	Merredin
WA	Urology	Port Headland

State	Speciality	Town/Region
SA	Cardiology	Ceduna
SA	Cardiology	Ceduna
SA	Cardiology	Coober Pedy
SA	Cardiology	Crystal Brook
SA	Cardiology	Peterborough
SA	Cardiology	Roxby Downs
SA	Dermatology	Wallaroo
SA	Dermatology	Berri
SA	Dermatology	Maitland
SA	Dermatology	Port Pirie
SA	Dermatology	Renmark
SA	Eye Surgeon	Roxby Downs
SA	Gastroenterologist	Berri
SA	General Physician	Kingscote
SA	General Surgeon	Ceduna
SA	Geriatric Medicine	Ceduna
SA	Geriatric Medicine	Renmark
SA	Geriatric Medicine	Cummins
SA	Geriatric Medicine	Elliston
SA	Geriatric Medicine	Kingscote
SA	Geriatric Medicine	Tumby Bay
SA	Gynaecology	Keith
SA	Gynaecology	Bordrtown
SA	Ophthalmology	Amata
SA	Ophthalmology	Ceduna
SA	Ophthalmology	Coober Pedy
SA	Ophthalmology	Fregon
SA	Ophthalmology	Indulkana
SA	Ophthalmology	Koonibba
SA	Ophthalmology	Maree
SA	Ophthalmology	Mimili
SA	Ophthalmology	Northern Flinders
SA	Ophthalmology	Nyapari
SA	Ophthalmology	Oak Valley
SA	Ophthalmology	Oodnadatta
SA	Ophthalmology	Pipalyatjara
SA	Ophthalmology	Pukatja
SA	Ophthalmology	Watarru
SA	Ophthalmology	Yalata
SA	Paediatric Neurology	Mt Gambier
SA	Paediatrician	Copley
SA	Paediatrician	Iga Warta
SA	Paediatrician	Kingscote
SA	Paediatrician	Leigh Creek
SA	Paediatrician	Pitjantjatjara communities

SA	Paediatrician	Port Lincoln
SA	Paediatrician Endocrinology	Port Lincoln
SA	Palliative Care	Andamooka
SA	Palliative Care	Ardrossan
SA	Palliative Care	Cowell
SA	Palliative Care	Hawker
SA	Palliative Care	Jamestown
SA	Palliative Care	Kadina
SA	Palliative Care	Maitland
SA	Palliative Care	Minlaton
SA	Palliative Care	Moonta
SA	Palliative Care	Mt Gambier
SA	Palliative Care	Naracoorte Hub
SA	Palliative Care	Naracoorte Hub - Bordertown
SA	Palliative Care	Naracoorte Hub - Keith
SA	Palliative Care	Port Augusta
SA	Palliative Care	Port Lincoln Hub
SA	Palliative Care	Port Lincoln Hub - Ceduna
SA	Palliative Care	Port Lincoln Hub - Coffin Bay
SA	Palliative Care	Port Lincoln Hub - Elliston
SA	Palliative Care	Port Lincoln Hub - Kimba
SA	Palliative Care	Port Lincoln Hub - Streaky Bay
SA	Palliative Care	Port Lincoln Hub - Wudinna
SA	Palliative Care	Port Pirie Hub
SA	Palliative Care	Port Pirie Hub - Booleroo Centre
SA	Palliative Care	Port Pirie Hub - Jamestown
SA	Palliative Care	Port Pirie Hub - Peterborough
SA	Palliative Care	Port Pirie Hub - Port Broughton
SA	Palliative Care	Renmark Hub
SA	Palliative Care	Roxby Downs
SA	Palliative Care	Tumby Bay
SA	Palliative Care	Wallaroo
SA	Palliative Care	Whyalla
SA	Palliative Care	Yorketown
SA	Pallitaive Care	Port Lincoln
SA	Physician	Maitland
SA	Anaesthetics Upskilling	Barmera
SA	Anaesthetics Upskilling	Clare
SA	Anaesthetics Upskilling	Kangaroo Island
SA	Anaesthetics Upskilling	Pt Lincoln
SA	Obstetric Upskilling	State wide
SA	Psychiatry	Loxton
SA	Psychiatry	Pitjantjatjara communities
SA	Psychiatry-Adult	Andamooka
SA	Psychiatry-Adult	Ceduna
SA	Psychiatry-Adult	Coober Pedy
SA	Psychiatry-Adult	Port Lincoln

SA	Psychiatry-Adult	Roxby Downs
SA	Psychiatry-Adult	Tailem Bend
SA	Psychiatry-Child & Adolescent	Ceduna
SA	Psychiatry-Child & Adolescent	Clare
SA	Psychiatry-Child & Adolescent	Crystal Brook
SA	Psychiatry-Child & Adolescent	Kangaroo Island
SA	Psychiatry-Child & Adolescent	Mt Gambier
SA	Psychiatry-Child & Adolescent	Port Augusta
SA	Urology	Berri
SA	Urology	Kingscote

State	Specialty	Town/ Region
Qld	Anaesthetist	Gympie
Qld	Dermatology	Charleville
Qld	Dermatology	Charters Towers
Qld	Dermatology	Cunnamulla
Qld	Dermatology	Goondiwindi
Qld	Dermatology	Hughenden
Qld	Dermatology	Mackay
Qld	Dermatology	Richmond
Qld	Dermatology	Roma
Qld	Dermatology	Thursday Island
Qld	Diabetologist	Aurukun
Qld	Diabetologist	Bamaga
Qld	Diabetologist	Coen
Qld	Diabetologist	Hope Vale
Qld	Diabetologist	Kowanyama
Qld	Diabetologist	Mapoon
Qld	Diabetologist	Napranum
Qld	Diabetologist	Pormpuraaw
Qld	Diabetologist	Thursday Island and Outer Islands
Qld	Diabetologist	Weipa
Qld	Diabetologist	Wujal Wujal
Qld	Ear, Nose and Throat	Aurukun
Qld	Ear, Nose and Throat	Bundaberg
Qld	Ear, Nose and Throat	Cooktown
Qld	Ear, Nose and Throat	Gladstone
Qld	Ear, Nose and Throat	Gladstone
Qld	Ear, Nose and Throat	Hope Vale
Qld	Ear, Nose and Throat	Rockhampton
Qld	Ear, Nose and Throat	Wujal Wujal
Qld	General Physician	Gympie
Qld	General Physician	Hervey Bay
Qld	General Physician	Maryborough
Qld	General Surgery	Gympie
Qld	GP Upskilling - Women's Health and Cancer	Townsville
Qld	Obstetrics and Gynaecology	Cloncurry
Qld	Obstetrics and Gynaecology	Doomadgee
Qld	Obstetrics and Gynaecology	Woorabinda
Qld	Oncologist	Bundaberg
Qld	Ophthalmology	Cunnamulla
Qld	Ophthalmology	Emerald
Qld	Ophthalmology	Emerald
Qld	Ophthalmology	Gympie
Qld	Ophthalmology	Maryborough
Qld	Ophthalmology	Rockhampton

Qld	Orthopaedics	Biloela
Qld	Orthopaedics	Monto
Qld	Orthopaedics	Moura
Qld	Orthopaedics	Theodore
Qld	Orthopaedics - GP Upskilling and Professional Support	Bundaberg
Qld	Paediatrics	Arukun
Qld	Paediatrics	Atherton
Qld	Paediatrics	Bamaga
Qld	Paediatrics	Burketown
Qld	Paediatrics	Camooweal
Qld	Paediatrics	Charleville
Qld	Paediatrics	Coen
Qld	Paediatrics	Cooktown
Qld	Paediatrics	Cunnamulla
Qld	Paediatrics	Dajarra
Qld	Paediatrics	Dirranbandi
Qld	Paediatrics	Doomadgee
Qld	Paediatrics	Goondiwindi
Qld	Paediatrics	Hope Vale
Qld	Paediatrics	Injune
Qld	Paediatrics	Innisfail
Qld	Paediatrics	Kowanyama
Qld	Paediatrics	Laura
Qld	Paediatrics	Lockhart River
Qld	Paediatrics	Mapoon
Qld	Paediatrics	Mareeba
Qld	Paediatrics	Mitchell
Qld	Paediatrics	Mornington Island
Qld	Paediatrics	Mungindi
Qld	Paediatrics	Napranum
Qld	Paediatrics	Normanton
Qld	Paediatrics	Pormpuraaw
Qld	Paediatrics	Quilpie
Qld	Paediatrics	Roma
Qld	Paediatrics	St George
Qld	Paediatrics	Surat
Qld	Paediatrics	Thursday Island
Qld	Paediatrics	Weipa
Qld	Paediatrics	Wujal Wujal
Qld	Paediatrics	Yarrabah
Qld	Physician/Cardiologist	Clermont
Qld	Physician/Cardiologist	Dysart
Qld	Physician/Cardiologist	Moranbah
Qld	Psychiatry	Mt Isa
Qld	Renal Physician	Aurukun
Qld	Renal Physician	Bamaga

Qld	Renal Physician	Coen
Qld	Renal Physician	Hope Vale
Qld	Renal Physician	Kowanyama
Qld	Renal Physician	Lockhart River
Qld	Renal Physician	Napranum
Qld	Renal Physician	Pormpuraaw
Qld	Renal Physician	Thursday Island
Qld	Renal Physician	Weipa
Qld	Renal Physician	Wujal Wujal
Qld	Respiratory physician	Gladstone
Qld	Respiratory Physician	Mackay
Qld	Telepaediatrics	Mackay, Rockhampton, Gladstone, Hervey Bay, Emerald, Cairns, Bundaberg, Clermont, Dysart, Maryborough, Roma, Townsville, Proserpine
Qld	Vascular Surgeon	Mackay

State	Specialty	Town/ Region
Tas	Dermatology	Burnie
Tas	Forensic psychiatry	Burnie
Tas	Forensic psychiatry	Devonport
Tas	Forensic psychiatry upskilling	Burnie
Tas	Forensic psychiatry upskilling	Burnie and Devonport
Tas	Forensic psychiatry upskilling	Devonport
Tas	General psychiatry and psychogeriatrics	Burnie
Tas	General psychiatry and psychogeriatrics	Devonport
Tas	General psychiatry and psychogeriatrics	Flinders Island
Tas	General psychiatry and psychogeriatrics	King Island
Tas	General psychiatry and psychogeriatrics	Queenstown
Tas	General psychiatry and psychogeriatrics	Smithton
Tas	General surgery	Scottsdale
Tas	Neurology	Burnie/Somerset
Tas	Palliative medicine	Burnie and surrounding regional towns
Tas	Palliative medicine	Launceston and surrounding regional towns
Tas	Rheumatology	Deloraine
Tas	Rheumatology	Devonport
Tas	Rheumatology	Somerset (Burnie)
Tas	Rheumatology	St Helens
Tas	Urology	St Helens

State	Speciality	Town/ Region
NT	Anaesthetic Upskilling	Tennant Creek
NT	Anaesthetic Upskilling	Tennant Creek
NT	Anaesthetic Upskilling	Tennant Creek
NT	Anaesthetic Upskilling	Tennant Creek
NT	Anaesthetic Upskilling	Tennant Creek
NT	Community Physician	Alcoota
NT	Community Physician	Ali Curung
NT	Community Physician	Alice Springs
NT	Community Physician	Ampilatawatja
NT	Community Physician	Anyinginyi Congress
NT	Community Physician	Apatula (Finke)
NT	Community Physician	Areyonga
NT	Community Physician	Areyonga
NT	Community Physician	Bonya
NT	Community Physician	Canteen Creek
NT	Community Physician	Docker River
NT	Community Physician	Elliot
NT	Community Physician	Epanarra
NT	Community Physician	Haast's Bluff (Ikuntji)
NT	Community Physician	Hart's Range
NT	Community Physician	Hermannsburg (Ntaria)
NT	Community Physician	Imanpa
NT	Community Physician	Kings Canyon
NT	Community Physician	Kintore
NT	Community Physician	Lake Nash (Alpurrurulam)
NT	Community Physician	Laramba (Napperby)
NT	Community Physician	Marlinja
NT	Community Physician	Maryvale
NT	Community Physician	Mt Liebig
NT	Community Physician	Mutitjulu
NT	Community Physician	Nyrripi
NT	Community Physician	Papunya
NT	Community Physician	Santa Theresa
NT	Community Physician	Stirling
NT	Community Physician	Tara
NT	Community Physician	Tennant Creek
NT	Community Physician	Ti Tree- 6 Mile
NT	Community Physician	Ti Tree- Station
NT	Community Physician	Ti Tree- Town
NT	Community Physician	Titjikala (Maryvale)
NT	Community Physician	Utopia
NT	Community Physician	Wallace Rock Hole
NT	Community Physician	Willowra
NT	Community Physician	Yuelumu (Mt Allen)
NT	Community Physician	Yuendumu

NT	Community Physician	Yulara
NT	Coordinator/ Admin support	Tennant Creek Hospital
NT SOS	Diabetes and High Risk Foot Clinic	Batchelor
NT	Diabetes and High Risk Foot Clinic	Willowra
NT	Diabetes and High Risk Foot Clinic	Yuendumu
NT	Diabetes and High Risk Foot Clinic	Multiple CA communities
NT SOS	Ear, Nose and Throat	Daly River
NT SOS	Ear, Nose and Throat	Danila Dilba
NT SOS	Ear, Nose and Throat	Darwin Renal Unit
NT SOS	Ear, Nose and Throat	Jabiru
NT SOS	Obstetrics and Gynaecology	Kunbarllanjnja (Oenpelli)
NT	Obstetrics and Gynaecology	Alcoota
NT	Obstetrics and Gynaecology	Ali Curung
NT SOS	Obstetrics and Gynaecology	Alyangula (Groote Eylandt) (Umbakumba to Groote)
NT	Obstetrics and Gynaecology	Ampilatawatja
NT SOS	Obstetrics and Gynaecology	Angurugu (Groote Eylandt)
NT	Obstetrics and Gynaecology	Anyinginyi Congress
NT	Obstetrics and Gynaecology	Apatula (Finke)
NT	Obstetrics and Gynaecology	Areyonga
NT SOS	Obstetrics and Gynaecology	Barunga
NT SOS	Obstetrics and Gynaecology	Beswick
NT SOS	Obstetrics and Gynaecology	Binjari
NT	Obstetrics and Gynaecology	Bonya
NT SOS	Obstetrics and Gynaecology	Borroloola
NT SOS	Obstetrics and Gynaecology	Bulman
NT	Obstetrics and Gynaecology	Canteen Creek
NT	Obstetrics and Gynaecology	Docker River
NT	Obstetrics and Gynaecology	Elliot
NT	Obstetrics and Gynaecology	Epanarra
NT SOS	Obstetrics and Gynaecology	Galiwin'ku (Elcho Island)
NT SOS	Obstetrics and Gynaecology	Gapuwiyak
NT	Obstetrics and Gynaecology	Haast's Bluff (Ikuntji)
NT	Obstetrics and Gynaecology	Hart's Range
NT	Obstetrics and Gynaecology	Hermannsburg (Ntaria)
NT	Obstetrics and Gynaecology	Imanpa
NT	Obstetrics and Gynaecology	Kings Canyon
NT	Obstetrics and Gynaecology	Kintore
NT	Obstetrics and Gynaecology	Lake Nash (Alpurrurulam)
NT	Obstetrics and Gynaecology	Laramba (Napperby)
NT SOS	Obstetrics and Gynaecology	Maningrida
NT	Obstetrics and Gynaecology	Marlinja
NT SOS	Obstetrics and Gynaecology	Milikapiti
NT SOS	Obstetrics and Gynaecology	Milingimbi
NT SOS	Obstetrics and Gynaecology	Minjilang
NT SOS	Obstetrics and Gynaecology	Miwatj
NT	Obstetrics and Gynaecology	Mt Liebig

NT	Obstetrics and Gynaecology	Mutitjulu
NT SOS	Obstetrics and Gynaecology	Nguiu (Bathurst Island)
NT SOS	Obstetrics and Gynaecology	Nhulunbuy (Gove Hospital)
NT SOS	Obstetrics and Gynaecology	Numbulwar
NT	Obstetrics and Gynaecology	Nyrripi
NT	Obstetrics and Gynaecology	Papunya
NT SOS	Obstetrics and Gynaecology	Peppimenarti
NT SOS	Obstetrics and Gynaecology	Pirlangimpi
NT SOS	Obstetrics and Gynaecology	Ramingining
NT	Obstetrics and Gynaecology	Santa Theresa
NT	Obstetrics and Gynaecology	Stirling
NT	Obstetrics and Gynaecology	Tara
NT	Obstetrics and Gynaecology	Tennant Creek
NT	Obstetrics and Gynaecology	Ti Tree- 6 Mile
NT	Obstetrics and Gynaecology	Ti Tree- Station
NT	Obstetrics and Gynaecology	Ti Tree- Town
NT	Obstetrics and Gynaecology	Titjikala (Maryvale)
NT	Obstetrics and Gynaecology	Utopia
NT SOS	Obstetrics and Gynaecology	Wadeye
NT	Obstetrics and Gynaecology	Wallace Rock Hole
NT SOS	Obstetrics and Gynaecology	Warrawi (Goulburn Island)
NT	Obstetrics and Gynaecology	Willowra
NT SOS	Obstetrics and Gynaecology	Yirrkala
NT	Obstetrics and Gynaecology	Yuelumu (Mt Allen)
NT	Obstetrics and Gynaecology	Yuendumu
NT	Obstetrics and Gynaecology	Yulara
NT SOS	Ophthalmology	Alyangula
NT SOS	Ophthalmology	Alyangula
NT SOS	Ophthalmology	Angurugu (Groote Eylandt)
NT SOS	Ophthalmology	Bickerton island
NT SOS	Ophthalmology	Borroloola
NT SOS	Ophthalmology	Daly River
NT SOS	Ophthalmology	Danila Dilba
NT SOS	Ophthalmology	Djilkminggan (Duck Creek)
NT SOS	Ophthalmology	Galiwinku
NT SOS	Ophthalmology	Gapuwiyak
NT SOS	Ophthalmology	Gove Hospital
NT SOS	Ophthalmology	Jabiru
NT SOS	Ophthalmology	Jabiru
NT SOS	Ophthalmology	Kalkarindji (Wave Hill)
NT SOS	Ophthalmology	Katherine Hospital
NT SOS	Ophthalmology	Kildirk
NT SOS	Ophthalmology	Kunbarllanjnja (Oenpelli)
NT SOS	Ophthalmology	Lajamanu (Hooker Creek)
NT SOS	Ophthalmology	Maningrida
NT SOS	Ophthalmology	Mataranka
NT SOS	Ophthalmology	Minyeri

NT SOS	Ophthalmology	Nguiu
NT SOS	Ophthalmology	Nguiu (Bathurst Island)
NT SOS	Ophthalmology	Ngukurr
NT SOS	Ophthalmology	Ngukurr (Roper River)
NT SOS	Ophthalmology	Nhulunbuy Hospital
NT SOS	Ophthalmology	Oenpelli
NT SOS	Ophthalmology	Timber Creek
NT SOS	Ophthalmology	Umbakumba
NT SOS	Ophthalmology	Wadeye
NT SOS	Ophthalmology	Wurli Wurlinjang
NT	Paediatrics	Alcoota
NT	Paediatrics	Ali Curung
NT	Paediatrics	Ampilatawatja
NT	Paediatrics	Anyinginyi Congress
NT	Paediatrics	Apatula (Finke)
NT	Paediatrics	Areyonga
NT	Paediatrics	Bonya
NT	Paediatrics	Canteen Creek
NT	Paediatrics	Docker River
NT	Paediatrics	Elliot
NT	Paediatrics	Epanarra
NT	Paediatrics	Haast's Bluff (Ikuntji)
NT	Paediatrics	Hart's Range
NT	Paediatrics	Hermannsburg (Ntaria)
NT	Paediatrics	Imanpa
NT	Paediatrics	Kings Canyon
NT	Paediatrics	Kintore
NT	Paediatrics	Lake Nash (Alpurrurulam)
NT	Paediatrics	Laramba (Napperby)
NT	Paediatrics	Marlinja
NT	Paediatrics	Mt Liebig
NT	Paediatrics	Mutitjulu
NT	Paediatrics	Nyrripi
NT	Paediatrics	Papunya
NT	Paediatrics	Santa Theresa
NT	Paediatrics	Stirling
NT	Paediatrics	Tara
NT	Paediatrics	Tennant Creek
NT	Paediatrics	Ti Tree- 6 Mile
NT	Paediatrics	Ti Tree- Station
NT	Paediatrics	Ti Tree- Town
NT	Paediatrics	Titjikala (Maryvale)
NT	Paediatrics	Utopia
NT	Paediatrics	Wallace Rock Hole
NT	Paediatrics	Willowra
NT	Paediatrics	Yuelumu (Mt Allen)
NT	Paediatrics	Yuendumu

NT	Paediatrics	Yulara
NT SOS	Paediatric Upskilling	Alyangula (Groote Eylandt)
NT SOS	Paediatrics	Angurugu (Groote Eylandt)
NT	Psychiatry	Main Community
NT	Psychiatry	Main Community
NT	Psychiatry	Main Community
NT	Psychiatry	Main Community
NT	Psychiatry	Main Community
NT SOS	Surgery	Barunga
NT SOS	Surgery	Beswick
NT SOS	Surgery	Borroloola
NT SOS	Surgery	Galiwin'ku (Elcho Island)
NT SOS	Surgery	Gapuwiyak
NT SOS	Surgery	Kalkarindji (Wave Hill)
NT SOS	Surgery	Katherine Hospital
NT SOS	Surgery	Lajamanu (Hooker Creek)
NT SOS	Surgery	Milingimbi
NT SOS	Surgery	Ngukurr (Roper River)
NT SOS	Surgery	Nhulunbuy (Gove Hospital)
NT SOS	Surgery	Ramingining
NT SOS	Surgery	(Umbakumba & Numbulwar to Groote)
NT SOS	Surgery	Wurli Wurlinjang

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-185

OUTCOME 5: Rural Health Care

Topic: MULTIPURPOSE SERVICES

Hansard Page: CA 112

Senator Stephens asked:

(a) Under Multipurpose Services (MPSs) can you provide some information on the quality improvement program and how many comply and what are the issues around compliance in bringing the MPSs up to speed?

(b) Can you provide details of the new MPSs locations?

Answer:

(a) All MPS must undergo an accreditation process. This was agreed by the Australian Government and State/Territory Governments through the Multipurpose Services Quality Improvement Framework developed by the Australian Health Ministers Advisory Committee Rural Health Policy Subcommittee.

Compliance will be measured through improved service activity reporting recently negotiated with all State Governments, that specifically includes a question on the type of Quality Improvement Process undertaken by the MPS.

Day to day compliance issues are the responsibility of the MPS auspices which in most cases is the State Government, but also includes the local Council in one instance, and the Churches of Christ in another.

The Australian Government has also introduced the Leading Practice Support Program for MPS to assist services to implement quality improvement approaches, and to facilitate the transfer of ideas and knowledge to other MPS. Fifteen projects are being funded in 2003-04 and 2004-05 through this Program.

(b) As of 1 March 2004, four MPS have commenced operation in the 2003-04 financial year. The locations of these new MPS are:

Rylestone	NSW
Coolah	NSW
Barraba	NSW
Lightning Ridge	NSW

An additional two MPS are anticipated to commence operation prior to 30 June 2004. The locations of these two MPS are:

Winton	QLD
Hay	NSW

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-186

OUTCOME 5: Rural Health Care

Topic: RURAL AND REMOTE PHARMACY WORKFORCE DEVELOPMENT PROGRAM

Hansard Page: CA 113

Senator Stephens asked:

(a) How does the infrastructure grants scheme operate? Can you advise me where the funding has been allocated?

(b) How is the Rural and Remote Pharmacy Work Force Development Program addressing issues of Aboriginal and Torres Strait Islander participation in pharmacy workforce and attracting and retaining professional pharmacy skills in rural and remote areas?

Answer:

(a) The Rural and Remote Pharmacy Infrastructure Grant Scheme (RRPIGS) is funded under the Rural and Remote Pharmacy Workforce Development Program (RRPWDP) and is managed by the Pharmacy Guild of Australia as part of the Third Community Pharmacy Agreement with the Department.

The aim of the RRPIGS is to support the role of community pharmacists in rural and remote communities so that innovative projects can be developed, implemented and evaluated.

There are two types of grants awarded under the Scheme. Firstly, small grants of up to $20,000 are provided for local pharmacy initiatives and innovative concepts for the delivery of pharmacy services. Secondly, large grants of up to $150,000 are provided for projects that can have both local and national application.

On commencement, priority areas for the Scheme were identified by key stakeholders including the Department of Health and Ageing, the Pharmacy Guild of Australia, Pharmacy Schools, the University Departments of Rural Health and rural pharmacists. From these priorities, a range of key topics for both the large and small grants were developed. These topics include pharmacist re-entry initiatives, promotion of rural pharmacy, primary care role of community pharmacists, innovative locum relief models and national or regional mentoring systems.

Details of the grants awarded under the Scheme to date are at Attachment A.

(b) The RRPWDP addresses a number of factors identified by rural and remote pharmacists that impact on the attractiveness of rural practice and influence the retention of pharmacists in these areas.

Initiatives under the Program include the provision of scholarships for undergraduate study in pharmacy, allowances for rural clinical placements, access to a locum in an emergency, contributions to the costs borne by rural pharmacists in undertaking professional education and Pharmacy Academics at University Departments of Rural Health to support and educate rural pharmacy students.

Also under the Program, the Aboriginal and Torres Strait Islander Undergraduate Pharmacy Scholarship Scheme, offers three scholarships each year (worth up to $15,000 per annum for a maximum of four years) to encourage Aboriginal and Torres Strait Islander students to undertake studies in Pharmacy at University.

The Program also includes a promotional component to encourage and support careers in Pharmacy. To this end in 2003-04, the Pharmacy Guild has undertaken a television, radio and print media promotional campaign to emphasise the initiatives under the RRPWDP. This campaign includes the promotion of increased participation of Aboriginal and Torres Strait Islander people in the Pharmacy workforce as well as encouraging school leavers to undertake studies in Pharmacy.

ID	Grant Title	Recipient	Due for completion	Grant Money Allocated (ex GST)
2001/802	A collaborative approach to improve community health outcomes	Healthwise Pharmacy	01/03/2004	$135,000.00
2001/813	Accredited Pharmacist Services in Rural and Remote Areas - A Scholarship and mentor support program for pharmacists	Australian Association of Consultant Pharmacy	01/10/2003	$50,375.00
2001/817	Graduate tracking project: Analysis of pharmacy workforce trends and the efficacy of rural student placements	Monash University	01/08/2005	$133,812.00
2001/821	Providing support to rural pharmacy - the West Vic Rural Pharmacy Locum Service	West Vic Division of General Practice	01/04/2004	$115,370.00
2001/831	Providing sustainable pharmacy services in the southern coastal region of South Australia	University of South Australia	04/11/2003	$149,879.85
2001/835	The impact of community pharmacy services on rural communities	Curtin Uni of Technology	05/12/2003	$147,750.00
2001/842	A census survey of rural/remote community pharmacists in NSW to identify recruitment and retention factors	University of Sydney	30/09/2004	$20,000.00
2001/844	Scholarships to rural pharmacists to attend re-entry / update program at the University of Queensland	University of Queensland	31/03/2004	$20,000.00
2001/851	Promoting Rural pharmacy as a career option to year 10-12 school students in rural communities	Queensland Rural Medical Support Agency	01/04/2004	$20,000.00
2001/853	Improving the outcomes of anticoagulation in rural Australia: an evaluation of pharmacist-assisted monitoring of warfarin therapy	University of Tasmania	17/10/2003	$20,000.00
2001/856	An Australian national strategy and curriculum for pharmacy preceptor education and support	University of Sydney	01/09/2003	$174,302.00
2002/861	The development of a health promotion programme for pharmacist to improve public health in rural areas	Turvey Tops Capital Chemist	01/03/2004	$18,160.00
2002/865	The development of an aboriginal health worker pharmaceutical reference for remote health centres	Territory Health Services	17/09/2004	$61,000.00
2002/867	Implementation and evaluation of a multidisciplinary chronic pain management service in rural NSW	University of Sydney	01/07/2004	$149,975.00

2002/869	Community Pharmacy models for Asthma management in rural Australia	University of Sydney	31/03/2005	$149,005.00
2002/874	Rural bonded scholarships for pharmacy undergraduate students - a scoping project	James Cook University	01/03/2004	$26,986.00
2002/876	Pharmacy support for chronic condition management in Whyalla and Port Augusta communities	Monarch Pharmacy (invoiced by Uni of SA)	15/04/2004	$10,300.00
2002/877	Innovative marketing of rural and remote pharmacy practice via the digital medium	University of Tasmania	01/03/2004	$28,500.00
2002/886	Evaluation of a national strategy and curriculum for pharmacy preceptor education and support in Australia	Monash University	01/03/2005	$134,812.20

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-215

OUTCOME 5: Rural Health Care

Topic: REGIONAL HEALTH SERVICES

Hansard Page: CA 112

Senator Stephens asked:

With the 10 new Regional Health Services that are due to become operational this financial year, can you provide details of the priority regions for these services?

Answer:

The Department's Annual Report indicated 10 new Regional Health Services (RHSs) were expected to be approved within the next 12 months. The regions they will service are listed below:

Victoria

Alpine Community Care RHS to be located in North Eastern Victoria and will service the communities of: Bright/Porepunkah, Mount Beauty and Myrtleford.

Queensland

Western Corridor RHS is located in the Far Western Queensland and will provide fly-in fly-out services from Mt Isa, to the communities of Boulia, Bedourie, Birdsville, Windorah, Jundah and Stonehenge.

Matilda RHS to be located in Central Western Queensland will provide outreach services from Longreach to the communities of Aramac, Muttaburra, Barcaldine, Blackall, Ilfracombe, Yaraka, Jericho, Alpha, Tambo and Winton.

Gulf RHS to be located in the Gulf Region of Queensland and will provide services to the communities of Doomadgee, Mornington Island and Normanton.

Savannah RHS to be located in North Western Queensland will provide services to the communities of Mt Surprise, Georgetown, Forsayth, Croydon and Einasleigh.

Tasmania

Meander Valley RHS is located in the Central North of Tasmania and provides services to the communities of Deloraine, Westbury, Hadspen, Bracknell, Carrick and Mole Creek.

Western Australia

Pilbara RHS will address chronic disease issues in the region.

Northern Territory

Southern Barkly RHS to be located south east of Tennant Creek will provide services to the communities of Ali Curung, Murray Downs, Canteen Creek and Epenarra.

Santa Teresa RHS planned for the Central Arrernte region south east of Alice Springs to provide services for the Ltyentye Apurte community.

Central Australian Allied Health Planning RHS will develop a model for service provision in the remote cross-border region of South Australia, Western Australia and the Northern Territory (Ngaanyatjarra, Pitjantjatjara and Yankunytjatjara language groups)

All of the projects listed above are or will be in operation this financial year - Santa Teresa RHS is at the detailed planning phase of development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-201

OUTCOME 6: Hearing Services

Topic: Vouchers issued in 2003-04.

Hansard Page: CA 123

Senator Crossin asked:

(a) You indicated at the June 2003 Estimates that you anticipated a growth of 10,000 voucher clients for the 2003-04 financial year. Now you are saying that it is a projection for the year – a growth of 15,000 vouchers. Well, you have been under budgeted then. Is that the case? You have an anticipated growth of 10,000 vouchers. You have given out 15,000, and it is now February.

(b) Can you give me an actual number of vouchers allocated as of now?

Answer:

(a) At the June 2003 estimates, based on historical data, the Department estimated a growth in 2003-04 of approximately 10,000 vouchers compared to the number of vouchers issued in 2002-03 (160,918). Based on actual year to date figures it appears that this number may be as high as 15,000.

An increase in the number of vouchers issued does not necessarily result in an increased demand for funds, as expenditure in a financial year is determined by the number of vouchers redeemed. However, extra funding was sought in the Additional Estimates process as it was anticipated that a higher number of vouchers would be redeemed than originally estimated, and that there would be an increase in the demand for more expensive services.

(b) 107, 971 vouchers were issued as at the end of February 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-202

OUTCOME 6: Hearing Services

Topic: ACCESS TO THE COMMONWEALTH HEARING SERVICES PROGRAM BY PARTICIPANTS IN THE COMMUNITY DEVELOPMENT EMPLOYMENT PROGRAM (CDEP)

Hansard Page: CA 129

Senator O'Brien asked:

(a) What would be the cost of extending the program to CDEP recipients?

(b) Can you model the incidence of hearing impairment in that community?

Answer:

(a) $14 million over four years or $3.5 million per year.

(b) Figures are available for the incidence of hearing loss in the Indigenous community in general (approximately 40%), but not specifically for communities participating in CDEP. It has been assumed that the hearing loss rate among CDEP recipients is comparable to that applying to the Indigenous population as a whole.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-204

OUTCOME 6: Hearing Services

Topic: Eligibility requirements under the Hearing Services Program.

Hansard Page: CA 130

Senator Crossin asked:

What makes you a voucher eligible client, please provide a table?

Answer:

Eligibility under the Voucher System is prescribed by the *Hearing Services Administration Act 1997*. To be eligible, a person must be:

- an Australian citizen or permanent resident;
- over the age of 21; and
- a Pensioner Concession Card holder or a dependant of a card holder; or
- a Department of Veterans' Affairs (DVA) Gold Repatriation Health Card holder or dependant of a card holder; or
- a DVA White Repatriation Health Card holder (specifically for war related hearing loss) or dependant of a card holder; or
- a Sickness Allowance recipient or dependant of a Sickness Allowance recipient; or
- a referred CRS Australia client; or
- a member of the Australian Defence Force.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-205

OUTCOME 6: Hearing Services

Topic: MEETING WITH CENTRELINK

Hansard Page: CA 129

Senator Crossin asked:

Did a meeting with Centrelink occur in respect of eligibility of CDEP recipients? I am interested in knowing the outcomes of this meeting.

Answer:

After advising that a meeting would be held with Centrelink, it was recognised that they had no responsibility for determining the eligibility of CDEP recipients for the Commonwealth Hearing Service Program other than checking initial eligibility for income support payments. Consequently no meeting on the subject was held with Centrelink.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-206

OUTCOME 6: Hearing Services

Topic: Meeting with the Commonwealth Rehabilitation Service (CRS)

Hansard Page: CA 129

Senator Crossin asked:

Please tell me the outcome of the meeting with CRS regarding Indigenous people wanting to return to work?

Answer:

A meeting was held with the CRS on 2 July 2003. The CRS indicated that it would refer its clients to the Hearing Services Program when assistance with a hearing disability formed part of an overall rehabilitation program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-115

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: NATIONAL STRATEGIC FRAMEWORK FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Written Question on Notice

Senator Stephens asked:

(a) Has every state and territory signed up to this agreement?

(b) How long is it expected before all related programs will be put in place?

(c) When is the first Evaluation planned?

(d) Is it part of the Commonwealth and State health care agreements?

Answer:

(a) Yes. The *National Strategic Framework for Aboriginal and Torres Strait Islander Health 2003-2013: Framework for Action by Governments* received whole of government support in each jurisdiction, prior to being formally signed by all Health Ministers on 31 July 2003.

(b) Many of the National Strategic Framework action areas are already being implemented and it is expected that new initiatives will be implemented incrementally over the ten year life of the Framework according to priorities identified in each jurisdiction. This ten year timeframe deliberately recognises the long lead times required for establishment of many new initiatives in Aboriginal and Torres Strait Islander health, particularly the establishment or enhancement of services. Each Government is currently preparing implementation plans against the National Strategic Framework.

(c) The National Strategic Framework provides for an independent mid-term review in 2008 and an independent final evaluation in 2013. In addition all jurisdictions are required to provide annual health portfolio progress reports to Health Ministers and to publish biennial whole of government progress reports to Health Ministers. The first of these progress reports will be a whole of government report expected in July 2005.

(d) Yes. The Commonwealth and each State and Territory have committed to implementing the Australian Health Care Agreements 2003-08 in line with the principles in the National Strategic Framework for Aboriginal and Torres Strait Islander Health.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-116

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: LIFE EXPECTANCIES FOR ABORIGINAL AUSTRALIANS

Written Question on Notice

Senator Stephens asked:

Life expectancies for Aboriginal Australians currently sit at about 20 years less than the rest of the population. This is an urgent state of affairs – what targets are set in place to reduce that discrepancy and what time-frame is set for these goals?

Answer:

Life Expectancy
Life expectancy is an important headline indicator of the health and wellbeing of populations. Life expectancy is determined by a range of compounding factors including: bio-medical risk factors and genetics; education, socioeconomic status and employment; environmental, social and cultural factors; quality and access to the health system; and a sense of personal control.

Access to quality health care, particularly primary health care, is one key factor in reducing the gap in life expectancy for Aboriginal and Torres Strait Islander Australians compared to the total Australian population. It is fundamental to health maintenance and makes an important contribution to health gain. However, achieving improvements in life expectancy relies on policy and action across Australian Government and State and Territory portfolios.

Targets
In 1997 the Australian Health Ministers Conference (AHMC) endorsed an interim set of *National Performance Indicators for Aboriginal and Torres Strait Islander Health* (NPIs), with selected targets. The target relevant to a sub-set of indicators covering: early adult death, life expectancy at birth, and standardised mortality ratios for all causes was to achieve a 20% reduction in age standardised all causes mortality rate ratios over ten years.

AHMC agreed that jurisdictions should report annually against the indicators and targets and, where data were inadequate, should report progress in developing capacity to report. Annual reports against the interim indicators have been published for 1998-2000, and prepared for 2001 and 2002 against a refined set of 56 NPIs. While the NPIs have been reported against by all jurisdictions, comprehensive comparisons between jurisdictions and over time are not yet possible. The poor quality of Indigenous identification in administrative datasets including base population estimates and birth and death registrations has prevented assessment of national progress against the targets.

These reporting issues have not delayed action to address the determinants of the life expectancy gap. In 2003 the Australian Government and all State and Territory Governments endorsed the *National Strategic Framework for Aboriginal and Torres Strait Islander Health* to improve health sector and cross portfolio action over ten years. It has clear aims including increasing life expectancy to a level comparable with non-Indigenous Australians, decreasing mortality rates and strengthening the health care service infrastructure. However it does not set specific targets or benchmarks for the Australian Government or State and Territory Governments in recognition of the different circumstances and priorities of each jurisdiction. Reporting will record progress on the key result areas and against the national aims. Over time it will chart each government's progress against their own baselines.

Progress to date includes:

- Access to Medicare and the Pharmaceutical Benefits Scheme has improved, with MBS and PBS expenditure on Aboriginal and Torres Strait Islander people increasing by around 50% since 1996[1];
- The number of Indigenous-specific primary health care services funded by the Government has increased from 108 in 1997-98 to 152 in 2002-03[2];
- A 39% increase in the number of episodes of health care to Aboriginal and Torres Strait Islander people for primary health care services reporting between 1998 and 2001[3];
- Nation-wide sustained reductions in perinatal and infant mortality over last three to four decades[4 5 6 7];
- Jurisdiction level (NT) improvements in mortality over the last three decades from selected causes: communicable disease (includes respiratory) - down 62%; injury - down 33%[8];
- Regional improvement in birthweights (NT)[9] and decrease in vaccine preventable disease (Qld)[10];
- Service level reductions in sexually transmissible infections and improvements in childhood immunisation coverage (various locations)[11];
- Improvements in chronic disease care (decreased hospitalisation for complications) in the Torres Strait[12];
- Funding for the Aboriginal and Torres Strait Islander health program stands at more than $272 million in 2003-04, a growth of 99% since 1995-96. In the 1999-2000 Budget $78.8 million was provided over four years to improve Aboriginal and Torres Strait Islander people's access to primary health care. An additional $19.7 million was allocated in the 2001-02 Budget to commence in 2003-04.

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[1] Australian Institute of Health and Welfare, (2001) *Expenditure on health services for Aboriginal and Torres Strait Islander People 1998-99* p 32.

[2] *Service Activity Reports (SAR)* data (1998, 2001) Completion of annual *Service Activity Reports (SAR)* is required of OATSIH funded services. SAR data provides a comprehensive national database that describes the quantity and range of services provided, and some workforce data.

[3] *Service Activity Reports (SAR)* data (1998, 2001).

[4] Reid J, Trompf P, (1991) *The Health of Aboriginal Australia.*

[5] NT Department of Health and Community Services (DHCS), (2003) Annual Report 2002-2003, Department of Health and Community Services, Darwin.

[6] Australian Institute of Health and Welfare, (2002), *The Health and Welfare of Aboriginal and Torres Strait Islander People 2003.*

[7] Markey PJ, d'Espaignet ET, Condon JR & Woods M, (Territory Health Service), (1998) *Trends in the health of mothers and babies in the Northern Territory 1986-1995.*

[8] Condon J, Barnes A, Cunningham J, Smith L, (2003) *Improvements in mortality in the Northern Territory over four decades*, in press.

[9] Commonwealth Department of Health and Aged Care, (2001) *Better Health Care.*

[10] Hanna J. et al, (2001) *The initial coverage and impact of the pneumococcal and influenza vaccination program for at-risk Indigenous adults in Far North Queensland*, Australian and New Zealand Journal of Public Health, Vol. 25 No. 6.

[11] Commonwealth Department of Health and Aged Care, (2001) *Better Health Care.*

[12] McDermott R, Tulip F, Schmidt B, Sinha A, (2003) *Sustaining better diabetes care in remote Indigenous Australian communities*, BMJ 327, pp 428-430.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-118

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: TRAINING

Written Question on Notice

Senator Stephens asked:

(a) For proportionate racial representation in the medical profession in Australia, we should have about 1260 Indigenous doctors; can the department provide information concerning the number of Indigenous doctors and mental health workers?

(b) Of the 6,925 psychologists in Australia, how many are Indigenous people?

(c) How many Indigenous medical practitioners are in practices or primary health care?

(d) What strategies does the department have in place to specifically increase the numbers of Indigenous doctors?

(e) Since more than half of Australia's Indigenous doctors have graduated from the University of Newcastle, can you tell us what efforts are being made to encourage the other nine medical schools to recruit and train Indigenous doctors?

(f) Is there a compulsory Indigenous health curriculum in each, or indeed any, of the postgraduate training programs?

Answer:

(a) According to the Australian Institute of Health and Welfare's *Health and Community Services Labour Force* 2001, 141 doctors identified as Indigenous in 2001. The term 'mental health worker' is not used in national health labour force statistics and no equivalent term is identifiable. Department of Health and Ageing data show that of 95 qualified counsellors, social workers and psychologists employed by its funded Indigenous primary health care services 52 identify as Indigenous.

(b) According to the Australian Institute of Health and Welfare's *Health and Community Services Labour Force* 2001, 19 clinical psychologists identified as Indigenous in 2001.

(c) According to the same source, 44 generalist medical practitioners identified as Indigenous in 2001 (the nearest proxy to 'in practices or primary health care' available).

(d) The Australian Health Ministers' Advisory Council's *Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework* (2002) details agreed strategies to increase Indigenous participation in the health workforce including medicine. They include:

- Joint action by State, Territory and Australian health departments working with the Australian Government's Department of Education, Science and Training to increase the number of Indigenous students in degree courses, develop curricula with Indigenous content and improve student recruitment and retention;
- Setting targets and incentives to ensure that Indigenous graduations in health courses are consistent with the Indigenous proportion of the Australian population;
- Researching demographic and other factors impacting on the choice of health careers by Indigenous students;
- Supporting the Australian Indigenous Doctors Association and the Congress of Aboriginal and Torres Strait Islander Nurses; and
- Developing cross sectoral support strategies at State and Territory level.

(e) The Department of Health and Ageing funds activities that encourage medical schools to recruit and train Indigenous doctors, including:

- Funding to the Australian Indigenous Doctors Association to provide support for its members including medical students with specific resources for a mentoring service for medical undergraduate and graduate students and identification of best practice recruitment and retention practices for Australian medical schools;
- High school visits to promote health careers including medicine to Indigenous school children;
- Scholarships to assist Indigenous medical students, primarily through the Puggy Hunter Memorial Scholarships Scheme; and
- Under **MedicarePlus** an additional 234 publicly funded medical school places have been made available in 2004, an increase of 16% in total places - this initiative will target areas of workforce shortage and will particularly benefit rural and remote areas where there is a high Aboriginal and Torres Strait Islander population.

(f) The medical specialists colleges have varying approaches to Indigenous content in postgraduate training for their members. The Royal Australian College of General Practitioners has compulsory Indigenous postgraduate curricula content developed in cooperation with the National Aboriginal Community Controlled Health Organisation. The Royal Australasian College of Physicians has syllabus guidelines for Indigenous health but not compulsory curricula content, which is currently under discussion. Additional information is available from individual medical colleges. The Department of Health and Ageing is currently working with the Committee of the Deans of Australian Medical Schools to develop and implement Indigenous content in undergraduate medical training. This will result in an Indigenous health curriculum for medicine courses to be linked to the accreditation process for medical schools.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-178

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: ADMINISTERED APPROPRIATIONS

Hansard page: CA 130-132

Senator O'Brien asked:

(a) [In relation to the figure for administered expenses in the 2002-03 Budget] do I take it that you would add at least $13.896 million to that figure to find out what was originally budgeted?

(b) On page 124 [of the PAES], in the column headed 2004-05, under the description "Rephased amounts for works projects" is a figure of $7.826 million. Where has that been rephased from?

(c) [In relation to revision of the 2003-04 Administered Expenses budget] which particular projects are the subject of the underspend carryover?

(d) [In relation to the activities and programs funded under the appropriation] where can I see the original breakdown of the line item?

Answer:

(a) The Office for Aboriginal and Torres Strait Islander Health (OATSIH) has rephased $13.896 million from 2002-03 to 2003-04, and $7.826 million from 2002-03 to 2004-05. That is, in 2002-03 OATSIH budgeted to spend $231.238 million but actually spent $209.516 million.

(b) $7.826 million was rephased from 2002-03 appropriation to 2004-05.

(c) The carryover relates to OATSIH capital works projects detailed in Attachment 1. This attachment shows the total cost for each project – it should be noted that OATSIH did record expenses against these projects in 2002-03.

(d) OATSIH's budget only has one administered item - Service in Aboriginal and Torres Strait Islander Health. There is no further breakdown in appropriation. OATSIH does divide up the appropriation for internal management purposes. These internal allocations can be varied throughout the year based upon changing priorities. Attachment 2 shows these allocations as at 31 January 2004.

State	Organisation	Project Type	Grant Amount
WA	Kimberley Aboriginal Medical Service Council	Health Worker Housing	$160,000
NT	Ampilawatja Health Centre Aboriginal Corporation	Clinic	$388,863
NT	Angurugu Community Government Council	Health Worker Housing	$410,000
Tas	Cape Barren Islanders Community Association	Nurses Housing	$230,000
NSW	Coomealla Health Aboriginal Corporation	Feasibility Study	$30,000
NT	Demed Association Incorporated Homeland Resource Centre	Clinic	$827,000
WA	Derby Aboriginal Health Service Council Aboriginal Corporation	Clinic	$4,211,000
Qld	Goondir Aboriginal Corporation for Health Services	Feasibility Study	$30,000
Qld	Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation	Clinic	$465,000
Qld	Karboyick Larkinjar Aboriginal Corporation for Health (Normanton)	Clinic	$130,000
NSW	Marrin Weejali Aboriginal Corporation	Feasibility Study	$30,000
WA	Mawarnkarra Health Service Aboriginal Corporation	Clinic	$3,075,000
Vic	Moogji Aboriginal Council East Gippsland Incorporated	Clinic	$1,039,000
WA	Wirraka Maya Health Service Aboriginal Corporation (Mumbultjari)	Feasibility Study	$60,000
WA	Ngaanyatjarra Health Service Aboriginal Corporation	Feasibility Study	$30,000
NT	Ngkarte Mikwekenhe Community Incorporated	Feasibility Study	$30,000
NSW	Orana Haven Aboriginal Corporation	Feasibility Study	$30,000
NSW	Roy Thorne Substance Rehabilitation Centre Incorporated	Feasibility Study	$30,000
Qld	Queensland Health Department	Health Worker Housing	$500,000
WA	Yura Yungi Medical Service Aboriginal Corporation	Doctors Housing	$320,000
NSW	Awabakal Newcastle Aboriginal Co-operative Limited	Clinic	$310,800
Qld	Ferdy's Haven Rehabilitation Aboriginal Corporation	Feasibility Study	$30,000
Qld	Goolburri Health Advancement Aboriginal Corporation	Feasibility Study	$30,000
Vic	Goolum Goolum Aboriginal Co-op	Clinic	$2,150,000
NT	Ilpurla Aboriginal Corporation	Feasibility Study	$30,000
Qld	Kambu Medical Centre Ipswich Incorporated (Ipswich/A&IHS)	Feasibility Study	$30,000
SA	Nganampa Health Council - Nyapari	Clinic	$371,000
SA	Nganampa Health Council - Umuwa	Admin Centre	$576,000
SA	Nganampa Health Council - Wattaru	Clinic	$371,000
SA	Nganampa Health Council - Yunyarinyi	Clinic	$371,000
WA	Nganggganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	Health Worker Housing	$440,000
WA	Ngunytju Tjitji Pirni	Clinic	$130,000
WA	Nindilingarri Cultural Health Services	Feasibility Study	$30,000
Vic	Wathaurong Aboriginal Cooperative	Clinic	$1,000,000
WA	Wirraka Maya Health Service Aboriginal Corporation (Pt Hedland)	Clinic	$655,000
Qld	Wunjuada Aboriginal Corporation for Alcohol and Drug Dependence	Clinic	$90,000
Qld	Yaamba Aboriginal and Torres Strait Islander Corporation for Men	Clinic	$200,000
WA	Yura Yungi Medical Service Aboriginal Corporation	Health Worker Housing	$332,800
SA	Goreta Aboriginal Corporation	Clinic	$344,850
ACT	Winnunga Nimmityjah Aboriginal Health Service	Clinic	$312,000
NT	Northern Territory Department of Health and Community Services	Health Professionals Housing	$4,490,000
NT	Northern Territory Department of Health and Community Services	Clinics	$2,578,000
			$26,898,313

Attachment 2

OATSIH allocation by program:

Program	Total $m
ATSIC/Army Community Assistance Program	4.1
Bringing Them Home	14.7
Capital Works[13]	10.1
Chronic Disease	1.4
Communication and Council of Australian Government Initiatives	1.4
Eye Health	3.3
Health[14]	102.8
Hearing	2.5
Immunisation	2.9
Male Health	0.2
Maternal and Child	0.7
Mental Health	6.2
Nutrition	0.1
Performance and Quality	0.8
Primary Health Care Access Program	43.6
Patient Information Recall Systems	1.9
Regional Planning	6.3
Remote Communities	9.4
Research and Data	2.4
Sexual Health	12.2
Substance Use	21.7
Workforce Planning	9.8
Total	**258.5**

[13] This is only part of total funding for capital works. Funding for capital works is also provided out of other program elements.
[14] This is in the main recurrent services funding line.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-179

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: CAPITAL WORKS

Hansard page: CA 132-133

Senator O'Brien asked:

(a) Do you know whether there are any major projects that were due to start in 2002-03 that did not start until 2003-04?

(b) Is there anywhere I can find a list of particular [capital works] projects for last year and this financial year?

Answer:

(a) The Office for Aboriginal and Torres Strait Islander Health capital works projects commence once an offer of funding is made and accepted by an organisation. Actual construction generally commences some time later following consultation with stakeholders, and completion of the detailed design and documentation including ensuring design compliance with local council building codes. Tenders are then called for construction which only commences once a successful tender has been selected and a contract for the works agreed. Funds for which rephasing is sought from 2002-03 for capital works are only for projects which had already commenced in 2002-03 due to acceptance of an offer.

(b) The table below identifies all projects under management of the Office as at February 2004. OATSIH manages the projects from the time the offer of funds is made, through the design and development phase, the construction and practical completion until the defects liability period has expired (usually 12 months after construction is completed).

OATSIH Capital Works Program – Schedule of Projects as at February 2004

State	Program Manager	Organisation	Funding Amount
ACT	ARUP	Winnunga Nimmityjah Aboriginal Health Service	$312,000
		1 Australian Capital Territory Project	**$312,000**

NSW	GHD	Aboriginal Medical Service Co-operative Ltd (AMS - Redfern)	$2,105,000
NSW	GHD	Baryulgil & Malabugilmah Health Outpost (Bulgarr Ngaru)	$168,500
NSW	GHD	Tharawal Aboriginal Corporation	$426,640
NSW	ARUP	Armidale & District Services Inc.	$1,953,800
NSW	ARUP	Awabakal Newcastle Aboriginal Co-operative Limited	$310,800
NSW	ARUP	Benelong's Haven Ltd	$125,000
NSW	ARUP	Bourke Aboriginal Community Controlled Health Service	$938,432
NSW	ARUP	Bulgarr Ngaru Medical Aboriginal Corporation	$1,127,273
NSW	ARUP	Condobolin Aboriginal Health Service Incorporated	$990,000
NSW	ARUP	Coomealla Health Aboriginal Corporation	$30,000
NSW	ARUP	Durri Aboriginal Corporation Medical Services	$1,181,818
NSW	ARUP	Marrin Weejali Aboriginal Corporation	$30,000
NSW	ARUP	Orana Haven Aboriginal Corporation	$30,000
NSW	ARUP	Pius X Aboriginal Corporation	$1,203,523
NSW	ARUP	Roy Thorne Substance Rehabilitation Centre Incorporated	$30,000
		15 New South Wales Projects	**$10,650,786**

NT	ATSIS	Aboriginal and Torres Strait Islander Services - Bonya Clinic	$920,658
NT	ATSIS	Aboriginal and Torres Strait Islander Services - Yuelumu Clinic	$1,111,219
NT	ATSIS	Aboriginal and Torres Strait Islander Services - Eastern Arrernte	$267,750
NT	GHD	Wadeye - Drs Housing - Kardu Numida Incorporated	$317,850
NT	NT Govt	NT DH&CS - Clinics	$2,578,000
NT	ARUP	Ampilawatja Health Centre Aboriginal Corporation	$388,863
NT	ARUP	Ampilawatja Health Centre Aboriginal Corporation	$90,000
NT	ARUP	Angurugu Community Government Council	$410,000
NT	ARUP	Anmatjere Community Government Council	$566,092
NT	ARUP	Anyinginyi Congress Aboriginal Corporation	$1,501,000
NT	ARUP	Anyinginyi Congress Aboriginal Corporation	$281,386
NT	ARUP	Central Australian Aboriginal Alcohol Programs Unit (CAAPU)	$1,885,275
NT	ARUP	Central Australian Aboriginal Congress Incorporated	$470,455
NT	ARUP	Council for Aboriginal Alcohol Program Services Incorporated	$364,091
NT	ARUP	Danila Dilba Medical Service Aboriginal Corporation	$129,091
NT	ARUP	Demed Association Incorporated Homeland Resource Centre	$827,000
NT	ARUP	Gapuwiyak Community Incorporated	$685,000
NT	ARUP	Ikuntji Community Council Incorporated	$524,160
NT	ARUP	Ilpurla Aboriginal Corporation	$33,360
NT	ARUP	Kalano Community Association Incorporated	$2,355,000
NT	ARUP	Katherine West Health Board - Minyerri House	$963,000
NT	ARUP	Laramba Community Council	$524,160
NT	ARUP	Ltyentye Apurte Community Government Council	$321,818
NT	ARUP	Malabam (Maningrida) Health Board Aboriginal Corporation	$462,000
NT	ARUP	Marthakal Homelands Resource Centre Association Incorporated	$340,000
NT	ARUP	Milingimbi & Outstations Progress Resource Association Incorporated	$500,000
NT	ARUP	Milyakburra Council (Health) Bickerton Island	$300,000
NT	ARUP	Miwatj Health Aboriginal Corporation	$900,000
NT	ARUP	Mutitjulu Community Health Service Aboriginal Corporation	$360,000
NT	ARUP	Ngaanyatjarra Health Service Aboriginal Corporation	$30,000
NT	ARUP	Ngaanyatjarra Pitjantjatjara Yankunytatjara Women's Council Aboriginal Corporation	$759,816
NT	ARUP	Ngkarte Mikwekenhe Community Incorporated	$30,000

NT	ARUP	NT DH&CS - Staff Housing	$4,490,000
NT	ARUP	NT DH&CS - Tiwi	$3,770,727
NT	ARUP	Nyrippi Community Council Incorporated (Walpiri Housing)	$370,477
NT	ARUP	Papunya Community Council Inc	$291,200
NT	ARUP	Pintubi Homelands Health Service	$1,500,000
NT	ARUP	Thangenharenge Aboriginal Corporation (Anmatjerre)	$267,750
NT	ARUP	Tiwi Health Pty Ltd T/A Tiwi Health Board Trust	$100,000
NT	ARUP	Umbakumba Community Council Incorporated	$307,273
NT	ARUP	Urapuntja Health Service Aboriginal Corporation	$260,259
NT	ARUP	Urapuntja Health Service Aboriginal Corporation	$509,091
NT	ARUP	Yuendumu Community Government Council - Willowra Housing	$524,160
		43 Northern Territory Projects	**$33,587,981**
QLD	GHD	Bamaga Island Council	$278,336
QLD	GHD	Cape York - Drs Housing	$240,000
QLD	GHD	Cherbourg Aboriginal Community Council	$205,358
QLD	GHD	Cunnamulla Aboriginal Corporation for Health	$280,000
QLD	GHD	Northern Peninsula Area Women's Services (Bamaga - NPAWS)	$1,027,500
QLD	GHD	Townsville Aboriginal and Islander Health Service Ltd (TAIHS)	$2,805,000
QLD	GHD	Wu Chopperen Medical Service Ltd	$800,992
QLD	Qld Health	Queensland Health Department - Thursday Island	$500,000
QLD	Qld Health	Queensland Health Department - Badu Island	$260,000
QLD	ARUP	Aboriginal and IslanderCommunity Health Services Brisbane Limited	$200,000
QLD	ARUP	Aborigines and Islanders Alcohol Relief Service Ltd - Douglas House	$2,301,870
QLD	ARUP	Charleville and Western Areas Aboriginal and Torres Strait Islanders Corporation	$329,091
QLD	ARUP	Congress Community Development and Education Unit Ltd (CCDEU - Townsville)	$481,818
QLD	ARUP	Ferdy's Haven Rehabilitation Aboriginal Corporation	$30,000
QLD	ARUP	Ferdy's Haven Rehabilitation Aboriginal Corporation	$376,000
QLD	ARUP	Goolburri Health Advancement Aboriginal Corporation	$30,000
QLD	ARUP	Goondir Aboriginal Corporation for Health Services	$30,000
QLD	ARUP	Gumbi Gumbi Aboriginal and Torres Strait Islanders Corporation	$465,000
QLD	ARUP	Kambu Medical Centre Ipswich Incorporated (Ipswich/A&IHS)	$30,000
QLD	ARUP	Karboyick Larkinjar Aboriginal Corporation for Health (Normanton)	$130,000
QLD	ARUP	KASH Aboriginal Corporation	$1,652,730
QLD	ARUP	Mackay Aboriginal Health Service	$2,414,675
QLD	ARUP	Mamu Medical Service Limited	$281,200
QLD	ARUP	Mookai Rosie-Bi-Bayan Aboriginal and Torres Strait Islander Corporation	$1,100,000
QLD	ARUP	Mudth-Niyleta Aboriginal and Torres Strait Islander Corporation	$30,000
QLD	ARUP	Mulungu Aboriginal Corp Medical Centre (Mareeba)	$255,500
QLD	ARUP	Queensland Aboriginal and Torres Strait Islander Corporation for Alcohol and Drug Dependence Service	$155,455
QLD	ARUP	Wunjuada Aboriginal Corporation for Alcohol and Drug Dependence	$90,000
QLD	ARUP	Yaamba Aboriginal and Torres Strait Islander Corporation for Men	$200,000
QLD	ARUP	Yarrabah Substance Misuse	$791,000
		30 Queensland Projects	**$17,771,525**

SA	SA Govt	South Australia Dept of Human Services	$575,455
SA	SA Govt	South Australia Dept of Human Services	$57,273
SA	ARUP	Ceduna Konibba Aboriginal Health Service	$665,350
SA	ARUP	Goreta Aboriginal Corporation	$344,850
SA	ARUP	Kalparrin Incorporated	$30,000
SA	ARUP	Nganampa Health Council	$371,000
SA	ARUP	Nganampa Health Council	$576,000
SA	ARUP	Nganampa Health Council	$90,000
SA	ARUP	Nganampa Health Council	$2,000,000
SA	ARUP	Nganampa Health Council	$518,182
SA	ARUP	Nunkuwarrin Yunti Incorporated	$527,750
SA	ARUP	Port Lincoln Aboriginal Health Service Incorporated	$177,080
SA	ARUP	South East Nungas Club Incorporated	$46,364
SA	ARUP	Yalata Maralinga Health Service Inc	$1,345,455
SA	ARUP	Yalata Maralinga Health Service Inc	$473,000
		15 South Australian Projects	**$7,797,759**
Tas	ARUP	Cape Barren Islanders Community Association	$230,000
Tas	ARUP	Flinders Island Aboriginal Association Incorporated	$60,000
Tas	ARUP	South East Tasmainia Aboriginal Corporation	$49,000
Tas	ARUP	Tasmanian Aboriginal Centre Incorporated	$350,000
		4 Tasmanian Projects	**$689,000**
Vic	ARUP	Goolum Goolum Aboriginal Co-op	$2,150,000
Vic	ARUP	Goolum Goolum Aboriginal Co-op	$29,091
Vic	ARUP	Lake Tyres Aboriginal Health and Childrens Services	$1,011,755
Vic	ARUP	Moogji Aboriginal Council East Gippsland Incorporated	$1,039,000
Vic	ARUP	Moogji Aboriginal Council East Gippsland Incorporated	$29,091
Vic	ARUP	Victoria Aboriginal Health Service Co-Op Ltd.	$159,000
Vic	ARUP	Wathaurong Aboriginal Cooperative	$1,000,000
		7 Victorian Projects	**$5,417,937**
WA	ARUP	Bega Garnbirringu Health Service	$440,000
WA	ARUP	Broome Aboriginal Medical Service	$262,000
WA	ARUP	Burringurrah Community Aboriginal Corporation	$920,883
WA	ARUP	Carnarvon Medical Service Aboriginal Corporation	$250,000
WA	ARUP	Derby Aboriginal Health Service Council Aboriginal Corporation	$310,000
WA	ARUP	Derby Aboriginal Health Service Council Aboriginal Corporation	$4,211,000
WA	ARUP	Geraldton Regional Aboriginal Medical Service	$2,106,950
WA	ARUP	Jurrugk Aboriginal Health Service Aboriginal Corporation	$260,000
WA	ARUP	Kimberley Aboriginal Medical Service Council - Beagle Bay	$245,000
WA	ARUP	Kimberley Aboriginal Medical Service Council - Bidyadanga	$160,000
WA	ARUP	Mawarnkarra Health Service Aboriginal Corporation	$3,075,000
WA	ARUP	Ngaanyatjarra Health Service Aboriginal Corporation	$360,000
WA	ARUP	Ngangganawili Aboriginal Community Controlled Health and Medical Services Aboriginal Corporation	$440,000
WA	ARUP	Ngunytju Tjitji Pirni	$130,000
WA	ARUP	Nindilingarri Cultural Health Services	$30,000
WA	ARUP	Nindilingarri Cultural Health Services	$561,632
WA	ARUP	Noongar Alcohol And Substance Abuse Service Incorporated	$2,699,964
WA	ARUP	Puntukurnu Aboriginal Medical Service Aboriginal Corporation	$400,000
WA	ARUP	Wheatbelt Aboriginal Corporation	$145,475
WA	ARUP	Wirraka Maya Aboriginal Corporation	$60,000

WA	ARUP	Wirraka Maya Health Service Aboriginal Corporation (Pt Hedland)	$655,000
WA	ARUP	Yura Yungi Medical Service Aboriginal Corporation - Halls Creek Housing	$320,000
WA	ARUP	Yura Yungi Medical Service Aboriginal Corporation - Halls CreekClinic	$1,012,871
WA	ARUP	Yura Yungi Medical Service Aboriginal Corporation - Ringers Soak Housing	$332,800
		24 Western Australian Projects	**$19,388,575**

Summary

1 Project - Australian Capital Territory	$312,000
15 Projects - New South Wales	$10,650,786
43 Projects - Northern Territory	$33,587,981
30 Projects – Queensland	$17,771,525
15 Projects – South Australia	$7,797,759
4 Projects – Tasmania	$689,000
7 Projects – Victoria	$5,417,937
24 Projects – Western Australia	$19,388,575
139 Total Projects nationally	**$95,615,563**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-180

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: EYE HEALTH REVIEW

Hansard page: CA 133

Senator O'Brien asked:

In relation to recommendations arising out of the review of eye health in the Aboriginal and Torres Strait Islander communities in 1997, can you tell me which recommendations were not implemented?

Answer:

The 1997 Report *Eye Health in Aboriginal and Torres Strait Islander Communities* underpinned the development of the National Aboriginal and Torres Strait Islander Eye Health Program. The recommendations of the Report were taken into account when developing the implementation arrangements for the Program. The following recommendations were not adopted:

(a) Recommendation 12a) A Medicare item number should be provided for annual retinal photographic screening for retinopathy in people with diabetes by practitioners other than ophthalmologists and optometrists.

(b) Recommendation 16) The Commonwealth Government should fund the establishment of a National Information Network to undertake the tasks that have been identified in this report. The Network would be a low-cost, small-scale organisation, possibly with a secretariat working on contract.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-181

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: EYE HEALTH

Hansard page: CA 133

Senator Crossin asked:

You have consistently stated to me that funding and final decisions are on hold until the review is completed. For example, in June last year, you said that two undisclosed major programs were delayed because the review had not been completed. Is that still the case?

Answer:

No.

During 2001/02 it was planned to complete the review of the implementation of the National Aboriginal and Torres Strait Islander Eye Health Program and conduct an eye health coordinators workshop. These were the two major activities that were delayed due to the necessity to go to tender twice to engage a suitable consultant to undertake the review. Both activities have now been completed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO
Additional Estimates 2003-2004, 18 February 2004

Question: E04-182

OUTCOME 7: Aboriginal and Torres Strait Islander Health

Topic: PHCAP EXPENDITURE

Hansard page: CA 135

Senator O'Brien asked:

Can you provide an update on the table provided on 18 December 2003 to show actual PHCAP expenditure in 2002-03 and budgeted amounts for 2003-04?

Answer:

	A	B	C	D	E
	Budgeted amounts 2002-03	**2002-03 PHCAP allocations for agreed capital works included in Budgeted amounts (column A) (construction in progress)**	**2002-03 PHCAP funding actual expenditure – (includes capital) to 30 June 2003**	**Budgeted amounts (includes capital) 2003-04**	**Agreed estimated population. levels (Indigenous Australians)**
Northern Territory wide	$329,000		$281,480	$874,000	
Tiwi	$3,824,499 (1)	$2,272,727	$1,572,042	$3,728,275	2,000
Katherine West	$2,978,727		$2,623,647	$2,915,675	3,060
Sunrise	$200,000		$200,000	$517,200	2,275
Anmatjera	$3,733,856 (1)	$3,640,521	$1,651,886	$457,546	1,464
Eastern Arrernte-Alyawarra	$2,427,676 (1)	$2,312,583	$815,714	$357,575	877
Northern Barkly	$718,341(1)	$624,750	$418,027	$632,079	821
Warlpiri	$2,702,681 (1)	$2,610,960	$1,537,110	$659,377	1,404
Luritja Pintupi	$2,644,516 (1)	$2,549,635	$1,121,807	$179,569	1,298
Darwin				$236,009	12,000
South East Top End				$2,527,702	1,310
South Australia					
Northern Metro	$1,270,942 (1)	$491,460	$779,482	$1,072,750	4,115
West & East Metro				$222,000	

	A	B	C	D	E
	Budgeted amounts 2002-03	**2002-03 PHCAP allocations for agreed capital works included in Budgeted amounts (column A) (construction in progress)**	**2002-03 PHCAP funding actual expenditure – (includes capital) to 30 June 2003**	**Budgeted amounts (includes capital) 2003-04**	**Agreed estimated population. levels (Indigenous Australians)**
Wakefield	$403,893 (1)	$344,850	$389,043	$457,205	758
Hills Mallee Southern				$229,224	1,390
Port Augusta sub-region	$348,000 (1)	$74,000	$348,000	$310,281	3,068
Riverland	$72,350		$72,350	$88,263	623
Mid North region				$71,792	611
South East region				$58,910	716
Eyre Region				$200,000	2098
Statewide				$53,500	25,497
Queensland					
Queensland wide	$13,000		$13,000	$138,397	
Atherton/Croydon	$36,000		$9,230	$483,400	4,180
Inland/Mt Isa	$36,000		$9,230	$487,046	4,315
Central Highlands	$36,000		$9,230	$443,684	1,688
Torres	$50,000		$50,000	$302,497	6,850
Near South West	$36,000		$9,230	$1,012,082	1,210
Gladstone				$45,793	1,985
Sunshine / Cooloola				$11,296	3,857
Cairns				$17,129	12,130
Ipswich & West Moreton				$20,958	4,971
Gulf	$165,000		$165,000	$508,750	3,796
Cook	$551,000		$402,000	$561,557	3,240
NSW					
Wilcannia	$696,450		$696,450	$696,450	1,000
Central Coast				$91,832	5,241
New England				$335,563	13,683
Mid Western				$290,916	7,173
Northern Rivers				$252,977	9,049
Greater Murray				$202,814	7,574
Far West				$164,012	7,597
Illawarra				$8,968	7,934
South Coast				$10,532	3,365*
Central West				$5,182	7,766*
Macquarie				$60,093	10,213
Western Australia					
South West Region/ including Perth and Bunbury	$2,733,137		$2,733,137	$1,421,776	30,600

Ngaanyatjarra Lands				$159,000	1,392
Mid-West Region				$122,569	7,569

	A	B	C	D	E
	Budgeted amounts 2002-03	**2002-03 PHCAP allocations for agreed capital works included in Budgeted amounts (column A) (construction in progress)**	**2002-03 PHCAP funding actual expenditure – (includes capital) to 30 June 2003**	**Budgeted amounts (includes capital) 2003-04**	**Agreed estimated population. levels (Indigenous Australians)**
Goldfields				$3,500	4,708
Pilbara Region (Roebourne and Ashburton Shires)				$404,311	2,611
Halls Creek/Kutjungka Region				$64,667	1,000
Kimberley W&NE region				$3,056,828	4,700
Victoria					
Barwon South Western				$652,319	2,467
Hume				$371,000	3,156
Central Gippsland				$40,000	1,026
Loddon Mallee				$40,000	4,256
Metropolitan Melbourne				$50,000	13,325
Statewide				$431,200	
ACT				**$150,000**	**3,909**
Tasmania				**$9,000**	**17,442**
TOTAL	**$26,007,068**	**$14,921,486**	****$15,907,095**	*** **$28,977,030**	

(1) includes capital allocations for works currently underway.

*1996 census data

**This figure is $6,234 higher than the figure provided in the November 2003 table due to an incorrect amount being transferred to that table for the Eastern Arrernte – Alyawarra and the Perth/Bunbury Regions. The figure has now been corrected.

*** 2003-04 Budget has increased from the 18 December 2003 budget estimate table as it now includes actual funding budget for new health service professionals and auxiliary staff (funding for some positions have recently been approved therefore budget includes only 2-3 months of salaries, not a full year effect). Also includes more recent budget information and approvals for new capital works, one off projects for additional medical and IT equipment, and support and training for health boards.

Department of Health and Ageing

Senate Community Affairs Legislation Committee
2003-04 Additional Estimates
Outcome 8 – Choice through Private Health

This morning Senator McLucas asked for the number of people in December 2003 with ancillary only cover, hospital only cover and combined hospital and ancillary cover.

I responded in terms of a ‘back of the envelope’ calculation.

The precise figures are:

1,254,929 people are covered by ancillary only policies
1.650,580 people are covered by hospital only policies
7,029,227 people are covered by combined hospital and ancillary policies

9,934,736 people are covered by either hospital or ancillary policies.

Dr Louise Morauta
First Assistant Secretary
Acute Care Division
18 February 2004

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-166

OUTCOME 8: Choice Through Private Health

Topic: CHOICE THROUGH PRIVATE HEALTH

Written Question on Notice

Senator Carr asked:

Please provide full details of each of the performance assessment mechanisms linked to the pay outcomes or other financial reward of individual employees etc.

Answer:

Staff of the Private Health Insurance Ombudsman are employed under individual contracts, under terms and conditions determined by the Ombudsman from time to time. The office has a performance appraisal system in place that is used to assist the Ombudsman with annual salary reviews. Salary advancement is subject to performance meeting agreed standards.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-168

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: PERFORMANCE ASSESSMENT MECHANISMS

Written Question on Notice

Senator Carr asked:

(a) Please provide full details of each of the performance assessment mechanisms linked to the pay outcomes or other financial reward of individual employees, including;

i. What are the current process/es of performance assessment within the portfolio agency? If more than one, please provide details of each, and the employee category it applies to.

ii. For each of the performance assessment process/es identified in (i), please list the range of outcome results an employee can achieve from each of the performance assessment processes identified in (i);

iii. For each of the performance assessment process/es identified in (i), what pay or other financial change is linked to each outcome or result for the employee from the performance assessment [ie, the pay increase or one-off bonus or classification or level change];

iv. For each of the performance assessments identified in (i), what is the classification level of employees subject to this performance assessment (eg SES, EL1, EL2 or APS and equivalent);

v. What is the principal industrial or other instrument governing each of the performance assessment mechanism/s (eg, the certified agreement or AWA);

vi. Does the performance assessment operates over a common cycle? Please provide the commencement and end dates of the most recent full cycle of each of the assessment process/es.

(b) For each performance assessment mechanism described in (a), advise the number of male and the number of female employees at each possible outcome, by classification level for the most recent full cycle (if the performance mechanism does not operate over a common cycle - aggregate outcomes using the 2002-03 financial year).

Answer:

(a)

(i) Performance Assessment is measured against individual performance agreements established at the beginning of each financial year. The performance agreements are developed from the Private Health Insurance Administration Council's strategic plan. It applies to all staff in the Private Health Insurance Administration Council.

(ii) An employee can achieve one of the following assessments:

- Outstanding
- Superior
- Effective
- Marginal
- Unsatisfactory.

(iii) Staff who have achieved a superior or outstanding rating are paid a one off bonus between 5% and 10%.

(iv) This applies to all staff in Private Health Insurance Administration Council from ASO 3 up to EL2.

(v) Individual contract.

(vi) Performance assessment is over a financial year. The most recent completed assessment cycle was 1July 2002 to 30 June 2003.

(b)

	Males	Females
Outstanding	1	
Superior	2	4
Effective	1	1
Marginal		
Unsatisfactory	1	

This information has not broken this down by classification as PHIAC is a small agency with 11 staff and such information could identify individuals.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-169

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: PERFORMANCE ASSESSMENT MECHANISMS

Written Question on Notice

Senator Carr asked:

(a) Please provide full details of each of the performance assessment mechanisms linked to the pay outcomes or other financial reward of individual employees, including;

i. What are the current process/es of performance assessment within the portfolio agency? If more than one please provide details of each, and the employee category it applies to;

ii. For each of the performance assessment process/es identified in (i), please list the range of outcome results an employee can achieve from each of the performance assessment processes identified in (i);

iii. For each of the performance assessment process/es identified in (i), what pay or other financial change is linked to each outcome or result for the employee from the performance assessment [ie, the pay increase or one-off bonus or classification or level change];

iv. For each of the performance assessments identified in (i), what is the classification level of employees subject to this performance assessment (eg SES, EL1, EL2 or APS and equivalent);

v. What is the principal industrial or other instrument governing each of the performance assessment mechanism/s (eg, the certified agreement or AWA);

vi. Does the performance assessment operate over a common cycle? Please provide the commencement and dates of the most recent full cycle of each of the assessment process/es.

(b) For each performance assessment mechanism in (a), advise the number of male and the number of female employees at each possible outcome, by classification level for the most recent full cycle (if the performance mechanism does not operate over a common cycle – aggregate outcomes using the 2002-03 financial year).

Answer:

(a) The performance assessment mechanisms linked to the pay outcomes or other financial reward of individual employees is as follows:

i. Currently a process of performance assessment within Medibank Private for employees on Australian Workplace Agreements (AWAs) is in the form of Performance and Development Plans (PDPs). The performance cycle works on an annual financial year calendar with a mid-year and end of year review. Performance measures are based on our Corporate and Divisional Plans and are set in conjunction with Managers.

Currently a process of performance assessment within Medibank Private for employees on Medibank Private's Certified Agreement is in the form of Performance and Development Plans (PDPs). The PDP process for Medibank Private's Front Line Leaders covered by the Certified Agreement has only recently been implemented across the organisation. The performance process works on an annual financial year calendar with a mid-year and end of year review. Performance measures are based on our Corporate and Divisional Plans and are set in conjunction with Managers.

For employees on Medibank Private's Certified Agreement who are not Front Line Leaders (the majority of Certified Agreement employees), it is intended that the PDP process be rolled out to those employees in the 2005 financial year.

All employees covered by Medibank Private's Certified Agreement participate in a Variable Incentive Plan (VIP) which is a performance based reward scheme which enables employees to earn up to 2% of their annual remuneration subject to meeting key divisional/team performance measures. The VIP is a quarterly scheme.

ii. For employees on an AWA, the PDP process is based on approximately 7 to 8 key measures applicable to each role. Performance on each measure is assessed on a 5 point scale – Outstanding, Very Good, Competent, Learning, and Needs Improvement.

For Front Line Leaders on Medibank Private's Certified Agreement, the PDP is based on a 5 point performance scale – Outstanding, Very Good, Competent, Learning, and Needs Improvement.

For employees on Medibank Private's Certified Agreement, the PDP when it is rolled out will be based on a similar 5 point performance scale – Outstanding, Very Good, Competent, Learning, and Needs Improvement.

All employees covered by Medibank Private's Certified Agreement participate in a Variable Incentive Plan (VIP) which is a performance based reward scheme which enables employees to earn up to 2% of their annual remuneration subject to meeting key divisional/team performance measures. The VIP is a quarterly scheme.

iii. For employees on an AWA, the performance outcome (rating attained) in PDP's is linked to potential remuneration and benefit changes. These include Medibank Private's Annual Remuneration Review process where the rating attained impacts the percentage remuneration increase (maximum 4%) an employee is eligible to receive and Medibank Private's Annual Incentive Plan (AIP) – performance based reward (maximum 15% of remuneration). Employees must receive at least a competent or learning (may be new to the role but still competent) rating to be eligible to participate in the scheme.

The Annual Incentive Plan (AIP) is an annual incentive scheme that is based on both individual and corporate objectives being achieved. 4 to 6 performance measures are established using the Corporate Plan, Divisional Plans and individual PDPs. Measures used in the AIP must be SMART – specific, measurable, achievable, realistic and timely.

For all Front Line Leaders covered by Medibank Private's Certified Agreement, the performance outcome (rating attained) during the PDP process is linked to potential remuneration changes. The PDP assessment is used to conduct a remuneration review process where the rating attained impacts the percentage remuneration increase an employee is eligible to receive up to a maximum of 4%.

Employees covered by Medibank Private's Certified Agreement who are not Front Line Leaders (majority of Certified Agreement employees) have their remuneration assessed on an annual incremental basis - based on the current Award structure (eg. Customer Service 0fficer (CS0) 1 to CS09).

All employees covered by Medibank Private's Certified Agreement participate in a Variable Incentive Plan (VIP) which is a performance based reward scheme which enables employees to earn up to 2% of their annual remuneration subject to meeting key divisional/team performance measures. The VIP is a quarterly scheme.

iv. Employees are currently either covered by the Medibank Private Certified Agreement or by Australian Workplace Agreements.

Front Line Leaders covered by Medibank Private's Certified Agreement are currently subject to the PDP process. All other Medibank Private Certified Agreement employees are assessed annually in accordance with Medibank Private's current Award structures. The classification levels include:

Customer Service Officer 1 to 9
Sales Specialist 1 to 10
Administrative Officer Grade 1 levels 1 to 8
Administrative Officer Grade 2 levels 1 to 5
Administrative Officer Grade 3 levels 1 to 4
Administrative Officer Grade 1 levels 1 to 4
Executive Officer Grade 1 levels 1 to 3
Executive Officer Grade 2 levels 1 to 5

v. All Medibank Private employees covered by Australian Workplace Agreements participate in the PDP and AIP processes.

All employees covered by the Medibank Private Certified Agreement participate in either the PDP process or receive incremental increases based on levels.

All employees covered by Medibank Private's Certified Agreement also participate in a Variable Incentive Plan (VIP) which is a performance based reward scheme which enables employees to earn up to 2% of their annual remuneration subject to meeting key divisional/team performance measures. The VIP is a quarterly scheme.

vi. The performance and development PDP process for AWA employees operates on an annual financial year calendar, with a mid-year and end of year review.

The Annual Incentive Plan (AIP) for AWA employees operates on an annual financial year calendar with an end of year review based on individual and corporate achievements.

The performance and development PDP process for Front Line Leaders covered by Medibank Private's Certified Agreement operates on an annual financial year calendar with mid-year and end of year review.

The Variable Incentive Plan (VIP) for all employees covered by Medibank Private's Certified Agreement, operates on a quarterly basis.

(b) As at March, 2004, the number of AWA employees currently under assessment in the PDP and AIP cycle is **285.** The total and percentage of male and female AWA employees currently under assessment in the PDP cycle are:

Male:	149	(52%)
Female:	136	(48%)

As at March, 2004, the number of employees covered by Medibank Private's Certified Agreement currently under assessment in the PDP cycle and Variable Incentive Plan is **1126**. The total and percentage of male and female CA employees currently under assessment in the PDP and VIP cycle are:

Male:	190	(17%)
Female:	936	(83%)

For the 2002/03 financial year (the most recent full cycle) of the PDP process for Medibank Private AWA employees (216 in total), the breakdown of ratings attained by male and female employees were:-

<u>Outstanding:</u>

Male	6
Female	3
Total	9

Very Good:

Male	47
Female	61
Total	108

Competent Measure

Male	48
Female	49
Total	97

Learning Measure

Male	1
Female	1
Total	2

Needs Improvement Measure

Male	0
Female	0
Total	0

For the most recent PDP cycle undertaken by Front Line Leaders covered by Medibank Private's Certified Agreement, the total breakdown of ratings attached were:-

Outstanding:	2	
Very Good:	40	
Competent:		73
Learning:		1
Needs Improvement:	1	

There is no breakdown between female and male data available.

For the balance of employees covered by Medibank Private's Certified Agreement, the PDP process is yet to be rolled out and there is no reportable data available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-139

OUTCOME 8: Choice Through Private Health

Topic: PROSTHESES

Written Question on Notice

Senator McLucas asked:

In response E03-133 (Supplementary Budget Estimates 2003-2004), it was stated that "In the form for submission of notification of changes to premiums for April 2004, health insurance funds have been asked to quantify the impact of the new arrangements for prostheses in their premium forecasts."

(a) Does this imply that agreement has been reached? If so, what is it? If not, on what basis are funds to quantify the impact?

(b) What has been the response from the funds to this request? (ie what sort of impact are they expecting?

Answer:

(a) The development work on the new prostheses arrangements proposal is not yet complete.

(b) Not applicable given (a) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-156

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: DNA ADVERTISING AGENCY

Hansard Page: CA 43

Senator McLucas asked:

(b) When you say they do not have a direct relationship with M&C Saatchi or Saatchi & Saatchi, does that mean they were potentially former employees, former partners or whatever who have moved completely out of those companies?

(c) You must have been concerned about the potential conflict. I would like to hear something a bit stronger than they 'don't have a direct relationship'.

(d) When did DNA establish itself as a company?

Answer:

(a) To clarify the initial answer given during Senate Estimates in which there was some confusion regarding if M&C Saatchi Agency or Saatchi & Saatchi was being referred to: Medibank Private can clarify that the structure of DNA Agency Network is composed of M&C Saatchi Agency as the principal shareholder with 90% of the shares in the company and Mr Michael Newman and Mr John Poulakakis each holding 5% shares in the company.

There is no direct relationship between DNA Agency Network and Saatchi & Saatchi. There is also no relationship between M&C Saatchi Agency and Saatchi & Saatchi.

(b) Information on the relationship between DNA Agency Network and M&C Saatchi Agency is clarified at a). It should also be noted that Mr Michael Newman was employed by Saatchi & Saatchi during the 1990's and left in 2001 and no longer has any commercial relationship with Saatchi & Saatchi. Mr Newman has never been employed by M&C Saatchi Agency. Mr John Poulakakis has never worked for Saatchi & Saatchi or M&C Saatchi Agency.

(c) DNA Agency Network was first established on 12 August 2003. M&C Saatchi Agency purchased the company on 12 November 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-157

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: LOW INCOME PRIVATE HEALTH INSURANCE HOLDERS

Hansard Page: CA 44

Senator McLucas asked:

I understand Medibank Private has made a statement about the number of people who have earnings of $30,000 or less. How many people does Medibank Private estimate have private health insurance who earn $30,000 a year or less?

Answer:

The statements that Medibank Private made were based on Australian Bureau of Statistics (ABS) data from a document titled, *ABS Private Health Insurance Survey*, June 1998, no. 4335.0.

Medibank Private estimated that 1.1 million Australians who had private health insurance earned $30,000 a year or less.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-158

OUTCOME 8 CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: 'EASING THE PRESSURE' REPORT

Hansard Page: CA 45

Senator Allison asked:

(a) Did you take legal advice about the conduct of this study?

(b) How many hard copies have been sent to members?

Answer:

(a) Medibank Private is satisfied that the commissioning of the report did not breach any relevant provisions of the National Health Act 1953 and confirmed that position with its legal counsel.

(b) 10 copies of the 'Easing the Pressure' report have been sent to Medibank Private members and 468 copies of the report have been downloaded from the Medibank Private Internet site as at 29 February 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-159

OUTCOME 8: Choice Through Private Health

Topic: PRIVATE HEALTH PARTICIPATION

Hansard Page: CA 109

Senator Allison asked:

Is it possible to get the figures that were tabled in relation to private health insurance coverage and were split between ancillary and hospital only cover, distinguished by age groups?

Answer:

No. The Private Health Insurance Administration Council does not collect information in this form.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-163

OUTCOME 9: Health Investment

Topic: PERFORMANCE ASSESSMENT MECHANISMS

Written Question on Notice

Senator Carr asked:

(a) Please provide full details of each of the performance assessment mechanisms linked to the pay outcomes or other financial reward of individual employees, including;

i. What are the current process/es of performance assessment within the portfolio agency? If more than one, please provide details of each, and the employee category it applies to.

ii. For each of the performance assessment process/es identified in (i), please list the range of outcome results an employee can achieve from each of the performance assessment processes identified in (i);

iii. For each of the performance assessment process/es identified in (i), what pay or other financial change is linked to each outcome or result for the employee from the performance assessment [ie, the pay increase or one-off bonus or classification or level change];

iv. For each of the performance assessments identified in (i), what is he classification level of employees subject to this performance assessment (eg SES, EL1, EL2 or APS and equivalent);

v. What is the principal industrial or other instrument governing each of the performance assessment mechanism/s (eg, the certified agreement or AWA);

vi. Does the performance assessment operates over a common cycle? Please provide the commencement and end dates of the most recent full cycle of each of the assessment process/es.

(b) For each performance assessment mechanism described in (a), advise the number of male and the number of female employees at each possible outcome, by classification level for the most recent full cycle (if the performance mechanism does not operate over a common cycle - aggregate outcomes using the 2002-03 financial year).

Answer:

(a)

(i) The current process for Non-SES staff is:

- at least one formal performance feedback meeting in the first 3 months of commencing in a new position or with a new manager;
- at least one meeting each 12 months thereafter.

The discussions are intended to cover:

- the employee's performance assessed against the requirements of the position, and any improvements necessary or desired;
- two-way feedback between employee and manager on issues affecting performance;
- learning and development options and priorities.

The manager is to write a record of the discussion and decisions, and provide a copy to the employee for signature and agreement. The manager is to keep this record in a secure place, and is to inform Employee Services section of the date the meeting was held, for reporting to the Executive Committee.

The current process for SES-staff has provision for Performance Agreements to be entered into, and assessment against agreed outcomes.

(ii) Outcome results:

- Training and development activities will be organised and undertaken throughout the year as opportunities arise, in accordance with priorities agreed during the performance feedback process;
- Matters noted as desiring improvement should be paid special attention by the manager and employee, and be a subject of informal day-to-day feedback;
- Employees may be assessed as either satisfactory or unsatisfactory. Employees assessed as satisfactory may advance one pay-point within their classification every 12 months until they are at the top pay point. For employees assessed as unsatisfactory, managers should seek information and advice from Employee Services section about options regarding formal inefficiency procedures.

(iii) For non-SES staff who are assessed as satisfactory, the financial change is a pay point advancement of one step per annum, unless they are already at the top of the range of their classification level. For SES staff who are assessed as satisfactory, an annual bonus of up to 5% of their salary is payable.

(iv) All non-SES are subject to the procedures as stated at (i) for that group. All SES staff are subject to the procedures as stated at (i) for SES.

(v) The AIHW Certified Agreement 2002-2005 covers staff up to and including EL2. The Performance Feedback Policy is not part of the CA but is referred to in the CA; changes or amendments to the Policy require the agreement of the parties to the CA. SES staff are covered by AWAs which provide for their performance assessment.

(vi) For non-SES staff, there is no common cycle. Due dates of assessments derive from the starting date of either the manager or employee in the job. For SES staff, the financial year is the common cycle, and dates of the most recent full cycle were 1 July 2002 – 30 June 2003.

(b) Male and Female employees at each possible outcome.

Based on our response to Question (a), we cannot answer all of Question (b) in the way it has been posed. However, we can provide the following information.

Outcome results at (a)iii

All three SES staff were eligible for, and received, a performance bonus of up to 5% of salary:

SES Band 1: Female 2 Male 1

Outcome results at (a)ii:

Employees eligible for pay point advancement: this outcome applies to non-SES staff who are not at the top of their classification range. Based on data readily available, less than 5% of eligible employees were refused pay point advancement on performance grounds during the financial year 2002-03.

The Institute puts emphasis on improving performance through training and development activities, identified and prioritised during the performance assessment procedures.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-098

OUTCOME 9: HEALTH INVESTMENT

Topic: JACKSON WELLS MORRIS

Written Question on Notice

Senator Forshaw asked:

(a) What services has Jackson Wells Morris provided to the Department of Ageing? Clarification was sought on this question as to whether it just related to Ageing or the Department of Health and Ageing. Senator Forshaw's office replied with "*Senator Forshaw has advised that the questions relate to the whole Department but he would like ageing related projects identified separately. The time frame is since 1996."*

(b) What are the contractual arrangements between Jackson Wells Morris and the Department?

(c) How much has Jackson Wells Morris been paid by the Department?

Answer:

(a) Jackson Wells Morris have provided the following services to the department:

(i) Public relations services and issues management advice on Health*Connect* and the draft National Health Privacy Code;

(ii) Public relations services and issues management advice on communications for the 1 January 2001 accreditation deadline for aged care facilities, at a cost of $91,703.

(b) NIL.

(c) The department has paid Jackson Wells Morris a total of $165,338.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-219

OUTCOME 9: Health Investment

Topic: NATIONAL STEM CELL CENTRE – RESEARCHER FUNDING

Hansard Page: CA 111

Senator Boswell asked:

Could you tell me how many grants have gone from the NHMRC and whether any money has gone? (to researchers who are participants in the National Stem Cell Centre).

Answer:

The NHMRC does not provide any funding to the National Stem Cell Centre.

The NHMRC does not require researchers to declare funding for research not supported by the NHMRC. The NHMRC is aware however that three current grants, all of which commenced funding in 2002, are held by researchers who also receive grants from the National Stem Cell Centre. The NHMRC projects do not overlap with National Stem Cell Centre funded grants.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-220

OUTCOME 9: Health Investment

Topic: STEM CELL RESEARCH - BRESAGEN

Hansard Page: CA 111

Senator Boswell asked:

BresaGen were to be a partner with the Trounson stem cell company. BresaGen have gone into receivership. Has the NHMRC paid any money to BresaGen?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04 - 140

OUTCOME: 9 : Health Investment

Topic: HIC ONLINE

Hansard Page: Written Question on Notice

Senator McLucas asked:

(a) How much does the HIC currently pay for the use of the MedClaims network?

(b) How is this spending broken down?

(c) What will happen to the MedClaims network as HIC Online gets up and running?

(d) What is the timeframe for the phase out of MedClaims?

(e) What are the savings for HIC when HIC Online is fully operational and fully rolled out?

(f) How much to date has been spent on HIC Online?

(g) How much more must be spent before it is fully rolled out?

(h) What will be the maintenance costs of a fully operational HIC Online?

(i) Will GPs be confronted with a situation where they will have no choice but to transfer to HIC Online?

(j) What will this cost GPs?

(k) Will doctors using HIC Online be required to pay a transaction cost?

(l) What will this cost be and what will it cover?

Answers:

(a) The Health Insurance Commission (HIC) currently pays an average of $560,946* per month ($6.73 million per annum) for access to the MedClaims network. These figures include GST.

* Based on payments made for the first seven months of 2003-04 (July 2003 to Jan 2004). The rate is variable according to usage.

(b) In 2003-04 MedClaims X400 email services have been purchased from four suppliers: IBA, Mednetwork, Connect and Telstra.

(c) HIC Online is intended to replace all of MedClaims. MedClaims uses two kinds of email, X400 email and Internet email. HIC only pays a fee for the X400 email. Most MedClaims email is X400 email.

In August 2001, the then Managing Director of the HIC, Dr Jeff Harmer, announced at an Industry Briefing that the HIC intended to develop the HIC Online product in collaboration with software vendors. Stakeholders were also advised that in time the HIC would migrate support for MedClaims to the HIC Online internet channel.

(d) The HIC has not yet set a date for the end of MedClaims. The HIC will continue MedClaims for as long as it is needed to support the Government's Medicare initiatives.

(e) HIC has estimated overall savings from reduced data entry of $40.15 million in the years 2003-04 to 2007-08.

(f) A total of $4.02 million was spent on the development of HIC Online desktop from 2001-02 to January 2004.

(g) No further development expenditure is planned in 2003-04 for HIC Online. Expenditure in 2004-05 or later years would occur if further functionality is incorporated into the product.

(h) Maintenance and ongoing costs for HIC Online desktop are estimated to $6.7 million from 2003-04 to 2007-08, or an average of $1.34 million per annum.

(i) GPs will always have the choice of claiming channels, including HIC Online and manual claiming. As noted above, the HIC anticipates that MedClaims will continue to be available for a period of time.

(j) The cost of the software is dependent on what the vendor charges for the Practice Management System. This cost varies between vendors. HIC Online capability is supplied to vendors free of charge.

Doctors who choose to access HIC Online will require a computer and a connection to the Internet via an Internet Service Provider. (Market research indicates that over 90% of doctors have both already). A computer will cost approximately $2,000 and incentive payments under the Practice Incentive Scheme may be available to offset this.

The location digital certificate that protects the privacy of the material sent by the doctor to the HIC is supplied at no cost by the Government-funded Health eSignature Authority (HeSA).

Under the **MedicarePlus** initiatives, doctors who take up HIC Online will receive a one-off transition payment of $750 or $1,000, depending on their location, to assist in these costs.

(k) No, there are no transaction costs for doctors using HIC Online over the public Internet. In addition to the initial set-up costs for doctors moving to HIC Online, the only ongoing cost is a connection to the Internet via an Internet Service Provider.

(l) HIC Online does not require a doctor to pay a transaction cost.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-191

OUTCOME 9: Health Investment

Topic: PARTICIPANTS OF THE AUSTRALIAN HEALTH INFORMATION COUNCIL (AHIC)

Hansard Page: CA 120

Senator McLucas asked:

Can I get on notice the participants of the Australian Health Information Council?

Answer:

The members of the **Australian Health Information Council** are:

Professor Andrew Justin Stewart Coats
Chair

Ms Patricia Faulkner
Chair of the National Health Information Group

Professor John Horvath
Australian Government

Dr Michael Price
Aged Care

Ms Yvonne Allinson
Professor Ric Day
Community/hospital pharmacy

Ms Margaret Brown
Ms Helen Hopkins
Consumers

Dr John Aloizos
Professor Michael Kidd
General practice

Dr Andrew Perrignon
Hospital

Ms Sally Goold
Indigenous health

Mr Robert Durie
Mr John Rimmer
Industry/communications

Professor Helen Christensen
Mental health

Mr Chai Chuah
New Zealand

Ms Jill Iliffe
Nursing

Associate Professor Peter Stewart
Pathology

Mr Stephen Nugent
Private health fund

Associate Professor Joan Cunningham
Public health

Professor Enrico Coiera
Dr Diana Hetzel
Professor Fiona Stanley AC
Research/statistical/health Informatics

Professor David Wilkinson
Rural health

Professor Bill Runciman
Medical specialists

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-192

OUTCOME 9: HEALTH INVESTMENT

Topic: THE AUSTRALIAN LONGITUDINAL STUDY ON WOMEN'S HEALTH
Hansard Page: CA 122

Senator McLucas asked:

Can I ask on notice, Dr Wooding, for you to look at the contract and see if there has been any request from the department to include new pieces of work. It may be something that has not been brought to your attention. If there have been other items that have been asked to be analysed, has there been any increased funding in order to do that work?

Answer:

There are seven research themes compared to five under the current agreement. Also, one content area report will be substituted for one technical report. A report will also be provided to the Office of the Status of Women as it is a funding partner of the study under the new agreement.

This new funding agreement will increase funding by $500,000 per year from the current contract.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-193

OUTCOME 9: HEALTH INVESTMENT

Topic: THE AUSTRALIAN LONGITUDINAL STUDY ON WOMEN'S HEALTH

Hansard Page: CA 122

Senator Allison asked:

It would be useful if the committee were notified when the contract was signed, given the longevity of this.

Answer:

The contract was signed by the Department on 12 March.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-194

OUTCOME 9: HEALTH INVESTMENT

Topic: THE AUSTRALIAN LONGITUDINAL STUDY ON WOMEN'S HEALTH

Hansard Page: CA 121

Senator Allison asked:

You say the contract is being renegotiated. What does that mean? Why would it not be simply tick off the last two years and do the same again?

Answer:

The contract has been renegotiated to include changes to the work program.

The Department did not extend the 2002 Contract because it needed to be updated to contain additional terms and conditions, and to reflect the nature of the research activities to be undertaken jointly by the University of Newcastle and the University of Queensland. This process required the involvement of the legal areas of the Department and the Universities of Queensland and Newcastle.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-195

OUTCOME 9 HEALTH INVESTMENT

Topic: MEDICONNECT – THE GUILD'S PATENT APPLICATIONS

Hansard Page: CA 117

Senator McLucas asked:

Have you received written advice from the Pharmacy Guild or from CR Group to say that their application for patents will not jeopardise the final effect of the Medi*Connect*?
If it is possible, could we receive a copy of that correspondence, if in fact it exits?

Answer:
Yes, a letter was received from Stephen Greenwood, Executive Director of The Pharmacy Guild of Australia dated 12 December 2003.

A copy of the letter is attached.

The PHARMACY GUILD of AUSTRALIA
NATIONAL SECRETARIAT

12 December 2003

Mr Alan Rennie
Assistant Secretary
Pharmaceutical Access and Quality Branch
Medical and Pharmaceutical Services Division
Department of Health and Aging
GPO Box 9848
CANBERRA ACT 2601

Dear Mr Rennie

Building Better e-Dispensing and e-Claiming Standards for Community Pharmacy (BEDAC)
- Contract between Commonwealth and the Pharmacy Guild of Australia

I refer to your letter of 20 November 2003 where you have raised certain issues regarding ownership of the invention (the '**Invention**') the subject of the international patent application filed in the name of the Guild, being International Publication Number WO 02/073456 (the '**Patent Application**').

Firstly, the Guild fully understands and appreciates that all intellectual property brought into existence pursuant to the terms of the 'Standards and Change Management Program Phase 2' project (the '**Standards and Change Management Agreement**') vests in the Commonwealth. Further, the Guild fully understands that all intellectual property brought into existence under the terms of the Agreement between the Commonwealth and the Guild relating to 'Building standards in e-enabled dispensing' and executed in December 2001 (the '**BEDAC' Agreement**') also vests in the Commonwealth. Importantly, the Guild fully understands that all intellectual property developed *utilising funds provided by the Commonwealth* under those agreements is owned by the Commonwealth.

Against this background, it is important from our point of view that the Commonwealth appreciates that the Invention described in the Patent Application was not developed pursuant to the terms of either of the above agreements or utilising any funds provided by the Commonwealth.

The history of this matter commenced prior to November 1999. Essentially:

1. Early phases of concept development for the Invention occurred as part of the development of the Guild's eHealth Strategy which was completed in November 1999. Further development of the Invention took place in 2000 and 2001, leading up to the filing of the Australian Provisional Application in March 2001.

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INTERNET www.guild.org.au

2. The Standards and Change Management Agreement commenced on 1 May 2000 and continued for less than two months: the final report was issued on 26 June 2000 ('**Report**'). The Invention was developed over a considerably longer period in work undertaken separately by the Guild and independently of Commonwealth Funding.

3. The Commonwealth was advised of the Guild's intention to pursue the Patent Application prior to the lodgement of the Australian provisional application in March 2001. A meeting was convened with officers of the Department and the HIC on 13 March 2001 to discuss the nature of the Invention and possible applications in the health sector. Key Ministerial staff were also briefed. The Commonwealth was invited to support development of the Invention at an early stage but declined this invitation.

4. The Guild raised the issue of the Invention, along with other initiatives pursued by the Guild, in the context of the BMMS (MediConnect) Development Group. These issues were brought to the attention of the Development Group at an early stage in a spirit of openness and not out of a concern for any direct conflict of interest.

   More recently (May 2003), the issue was revisited by the MediConnect Technical Working Group and the Guild's response is a matter of public record in the minutes of that meeting.

5. The Invention relates to a particular method and system for selective and secure sharing of the personal health data of a consumer. Contrary to what is suggested in your letter, no such method or system is described in the Report issued on 26 June 2000, either in the To Be Process Maps or elsewhere.

6. The Patent Application sets out a total of fifty claims defining the Invention. An indication of the scope of these claims is set out in the **attached** Annexure. A perusal of these claims shows that there is no overlap between the Invention as defined by the claims and the subject matter of the Report.

To Be Process Maps

Turning now to the To Be Process Maps set out in Annexure C of the Report, to which you have referred, the **attached** Annexure briefly compares the To Be Process Maps with the figures set out in the Patent Application ('**Patent Figures**') and the Invention as defined by the claims.

In summary, the To Be Process Maps in no way describe or represent the Invention described in the Patent Application, and there is no basis for suggesting that the Invention was developed pursuant to the Standards and Change Management Agreement or is incorporated in Agreement Material.

Medi*Connect*

You have raised the broader issue of the potential for the Guild's Patent Application to in some way compromise the developmental direction of Medi*Connect*.

As a key stakeholder in the Medi*Connect* project the Guild has always disclosed its interest in matters where there is any potential for or possible perception of a conflict of interest. As indicated above, the Commonwealth was advised of the Guild's intention to pursue the Patent Application at an early stage.

The Guild's view is that the Patent Application is in no way incompatible with Medi*Connect*. On the contrary, the Invention provides a capability which can be used to effectively support the goals of Medi*Connect*. Specifically, the particular method and system for selective and secure sharing of the personal health data of a consumer described in the Invention can be used to support Medi*Connect*'s goals of permitting, with consumer consent, doctors, pharmacists and authorised hospital staff to view information to treat consumers appropriately, and to add new medicines information to consumer's records.

The Guild's commitment to the Medi*Connect* project remains undiminished. More importantly, the core features of Medi*Connect*, namely a national public agency-managed repository of consumer medication records, are not jeopardized by the Guild's IT developments.

I am confident that the Guild can allay any further concerns you may have, concerning either the Invention or its relationship with Medi*Connect*.

Should you wish to clarify further any aspects of this matter, please let me know.

Yours sincerely

Stephen Greenwood
Executive Director

[redacted]

ANNEXURE

Patent Claims

The Patent Application sets out a total of fifty claims defining the Invention. Claim 1 is as follows:

1. A method for a health care provider to obtain personal health data relating to a consumer, the method comprising the steps of:

   the consumer causing personal health data to be stored in a secure repository, said repository requiring authentication of the consumer's identity before the consumer is provided access to the repository;

   the consumer selecting items of personal health data to share and identifying a health care provider, or class of health care providers, to whom access will be provided for those items of personal health data;

   a health care provider providing authentication of their identity to the consumer's secure repository and being provided access to those items of personal health data of the consumer for which the health care provider has been identified for sharing;

   the health care provider using the personal health data of the consumer to determine health care advice or the provision of a health care service for the consumer; and

   the health care provider recording details of the consultation and the advice or service provided to the consumer in the secure repository of health data of the consumer.

Further claims set out in the Patent Application relate to, amongst other things,:

- use of a pre-defined template for selection of items to be shared;
- the consumer granting permission to a health care provider to access the template;
- use of a filter to select data to be shared;
- use of a software program transferred from a health care provider to the secure repository of a consumer;
- provision of various specific kinds of reports to consumers;
- use of the methods where the health care provider is a physician or pharmacist; and
- use of digital security keys.

To Be Process Maps and the Patent Figures

The Patent Figures refer to a particular embodiment of the Invention, relating specifically to a method for dispensing pharmaceutical items to a consumer.

The To Be Process Maps set out a vision of roles, processes and work flows to support future e-commerce enabled dispensing and define data contained in the work flows.

Both the To Be Process Maps and the Patent Figures included in the Patent Application relate to pharmaceutical dispensing in an on-line networked environment in which data is

transferred between a number of persons and systems. As a result there are some resemblances between the To Be Process Maps and the Patent Figures. Some of the roles, persons and systems involved and, at a broad level, certain of the activities depicted in both the To Be Process Maps and the Patent Figures are similar.

However the Patent Figures differ significantly from the To Be Process Maps, and the Patent Figures are far more detailed. Specifically, and most importantly, the elements of the Invention are not represented or described in any way in the To Be Process Maps. In respect of Claim 1 of the Patent Application, for example, the To Be Process Maps do not refer to a secure repository, and do not refer to the sharing method and authorisation and authentication steps set out in Claim 1. In contrast, the Patent Figures set out the use and role of Consumer and Health Professional Keys for the authentication steps required as key elements of the Invention.

Not only are the elements of the Invention as set out in Claim 1 not represented in the To Be Process Maps, none of the further claims set out in the Patent Application are described or represented in the To Be Process Maps.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question:E04-197

OUTCOME 9 HEALTH INVESTMENT

Topic: MEDI*CONNECT - GP AGREEMENTS*

Hansard Page: CA 118/119

Senator McLucas asked:

(a) There is some commentary that GPs have been reluctant to sign up because of the confidentiality question and also because of liability questions. Is that your understanding as well? Do you have any information on that?

(b) There was an article in *Australian Doctor* towards the end of last year that said that the GP representative group responded to the department's second draft of the contracts being offered to GPs and had recommended that GPs actually contact their medical defence organisation before they sign them. What has happened since then?

Answer:

(a) & (b)
Issues relating to indemnity and liability have been raised during the negotiation of contracts with General Practitioners. These issues have been discussed with representative groups, including the General Practice Representative Group (GPRG), over a two-year period from July 2001. GPRG has provided comments to the Department. The Department, and HIC which has overall responsibility for the contracts with GPs and pharmacists, met with GPRG representatives on 22 January 2004 to discuss the issue of indemnity/liability.

Additional indemnity clauses have been drafted and agreed with the AMA. These are now with the GPRG for consideration.

In the meantime, interim contracts are being used to sign up providers who wish to participate in the Field Test. These contracts have been developed under the guidance of the Legal Services areas in both the Department and HIC. In the event that early signing has disadvantaged providers, adjustments will be made to these interim contracts.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-056

OUTCOME 9: Health Investment

Topic: Biotechnology Australia Fact Sheets

Written Question on Notice

Senator Harradine asked:

(a) I noticed that the NHMRC has withdrawn its logo from the Biotechnology Australia fact sheets. Did the NHMRC withdraw its logo because it had no confidence in the fact sheets?

(b) I asked a question which Dr Morris took on notice on 5 November last year. My question was "is the National Health and Medical Research, in effect, disowning this thing (the fact sheet on stem cells)"? I haven't seen an answer, despite Ms Halton's assurances at the time of a prompt response to my questions.

(c) Was Biotechnology Australia using the NHMRC logo without the NHMRC's permission?

(d) If Biotechnology Australia was using the NHMRC logo with the NHMRC's permission, why was that permission given when the NHMRC (had) not cleared the fact sheet?

(e) Does the NHMRC always check publications before its logo is used on publication? If so, why did it not do so in this case?

Answer:

(a) Biotechnology Australia has removed the NHMRC logo from the relevant fact sheets to comply with the new Australian Government branding guidelines. Each Fact Sheet on which the NHMRC Secretariat has been consulted now includes a statement acknowledging this consultation.

(b) A response was referred to the Committee on 27 January 2004 as QON E03 - 185: "What involvement did the NHMRC have in the preparation of the Biotechnology Australia Fact Sheet 26 and which area of the NHMRC was involved?"

Biotechnology Australia initiated an update of the Fact Sheet in May 2003. Biotechnology Australia sought feedback from the NHMRC Centre for Compliance and Evaluation on the revised Fact Sheet. Some minor changes were made by the NHMRC which were included prior to the Fact Sheet being placed on the Biotechnology Australia website.

In relation to your question “is the National Health and Medical Research, in effect, disowning this thing (the fact sheet on stem cells)":

Biotechnology Australia revised Fact Sheet 26 in May 2003 and sought feedback from the NHMRC Secretariat. While advice was provided at officer level, there was no formal clearance. Biotechnology Australia and the NHMRC Secretariat have now put in place improved arrangements for consultation on development and revision of Biotechnology Australia’s Fact Sheets.

(c) No.

(d) Permission had been given to use the NHMRC logo for the original version of Fact Sheet 26.

(e) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-057

OUTCOME 9: Health Investment

Topic: Bresagen

Written Question on Notice

Senator Harradine asked:

(a) Has the department made any research grants to the company Bresagen for projects that are yet to be completed?

(b) If so, what are they and how much money has been committed to each project?

(c) What steps are you taking to protect public funds given Bresagen is in voluntary administration?

Answer:

(a) No.

(b) Please refer to answer (a) above.

(c) Please refer to answer (a) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-058

OUTCOME 9: Health Investment

Topic: Minister's involvement on Human Cloning Issues

Written Question on Notice

Senator Harradine asked:

You indicated in an answer to question E03-059 (b) (Supplementary Budget Estimates 2003-2004) that the Minister responsible for human cloning issues at the time, Kevin Andrews, was not consulted.

(a) Why didn't the process of formulating the government's position on the UN international treaty on human cloning involve Mr Andrews?

(b) Wasn't he the Minister you would normally report to on cloning?

(c) If so, why was he not involved in the process?

(d) Wouldn't it be normal procedure for the Minister to receive a brief on the issue and to discuss with him your input to the position of the Australian Government?

(e) Did you keep any minister advised of your work on this issue?

(f) If so, which minister?

Answer:

(a) The formulation of the Government's position was determined by the appropriate government processes.

(b) Yes.

(c) The Prime Minister informed Minister Andrews of the Australian position. The process of formally briefing Minister Andrews on this matter was precluded by the announcement of a Cabinet reshuffle on 29 September 2003.

(d) The process of formally briefing Minister Andrews on this matter was precluded by the announcement of a Cabinet reshuffle on 29 September 2003.

(e) On 25 September 2003, the NHMRC provided a briefing on this matter to the Principal Adviser to Minister Andrews, in preparation for a briefing to Minister Andrews.

(f) See answer (e) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-059

OUTCOME 9: Health Investment

Topic: Embryo Research or Stem Cell issues

Written Question on Notice

Senator Harradine asked:

(a) Please provide me with copies of all speeches made by representatives of the NHMRC on embryo research or stem cell issues in the past year, including presentations at the 2nd Australian Stem Cell Summit on 11-12 March 2003, the 2nd Stem Cell Workshop on 4 June 2003, the 3rd Stem Cell Workshop on 14 October 2003 and a conference held by the National Stem Cell Centre on 9 October 2003.

Answer:

(a) Copies of presentations are provided at Attachments 2 to 18, with an index at Attachment 1. No speech was given by a representative of the NHMRC at the National Stem Cell Centre Conference on 9 October 2003, although a Program Abstract was provided. (Attachment 9).

[Note: attachments 2-18 have not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-060

OUTCOME 9: Health Investment

Topic: NHMRC LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

In answer to Question E03-061(a) (Supplementary Budget Estimates 2003-2004) you provided copies of the minutes of the NHMRC Licensing Committee. Please provide copies of minutes for any subsequent meetings.

Answer:

Copies of the Minutes of meetings of the NHMRC Licensing Committee held on 30 July 2003 and 29-30 September 2003 were provided in response to your Question EO3-061.

Minutes of the meeting of the NHMRC Licensing Committee held on 18-19 December 2003 are attached.

[Note: the attachment has not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-061

OUTCOME 9: Health Investment

Topic: NHMRC LICENSING COMMITTEE

Written Question on Notice

Senator Harradine asked:

(a) Has the Licensing Committee issued any licences?

(b) How many applications have been received?

(c) How many have been approved?

(d) Please provide details of the applications approved.

Answer:

(a) As at 12 March 2004 the NHMRC Licensing Committee has not issued any licences.

(b) As at 12 March 2004 the NHMRC Centre for Compliance and Evaluation had received ten applications for a licence to use excess assisted reproductive technology (ART) embryos (this includes one application that was subsequently withdrawn by the applicant).

(c) See answer (a) above.

(d) See answer (a) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-062

OUTCOME 9: Health Investment

Topic: CUSTOM REGULATION OF THE EXPORT OF HUMAN EMBRYOS

Written Question on Notice

Senator Harradine asked:

(a) Please provide copies of the minutes of meetings to date of the inter-departmental committee reviewing the customs regulation ban of the export of human embryos.

(b) Has the IDC completed its work?

(c) If so, please provide a copy of their findings.

Answer:

(a) Providing the information could reveal the deliberative processes of government. The outcome of the discussions at the IDC meetings is reflected in the report which is provided (see (c) below).

(b) No.

(c) A copy of the report is attached.

[Note: the report has not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-082

OUTCOME 9: Health Investment

Topic: CASE OF PROFESSOR BRUCE HALL AND DR CLARA HE

Written Question on Notice

Senator Carr asked:

In a letter to the Committee from Ms Suzanne Northcott, dated 25 June 2003, Ms Northcott provides a clarification of evidence given before the Committee in 5 June 2003.

She says, with regard to investigation by the Department's Audit and Fraud Control Branch of the allegation that Professor Bruce Hall had misused funds from Dr Clara He's NHMRC Grant (no. 113949), that:

"… the AFCB report found 'it would not be possible to substantiate a case that Professor Hall misused funds for grant 113949 in a manner which implies an offence under the Criminal Code."

(a) Can you advise the Committee, preferably by quoting from the AFCB report, whether the AFCB found that, despite the finding mentioned above, there were grounds to believe that Professor Hall might or could have misused the funds in question?

(b) How does the AFCB assess the evidence on balance?

(c) Can you provide more detailed information on the investigations conducted by the AFCB?

(d) What action has the NHMRC taken in response to the report by the AFCB?

Answer:

(a) The AFCB had concerns about the possible use of funds, but did not find that there were grounds to believe that Professor Hall might or could have misused the funds in question. The first relevant extract from the AFCB report is:

"Examination of the acquittals from the UNSW (at Attachment 6) indicate that:

- in the year ended 31 December 2000, $56,184 was expended on salaries and on-costs for Catherine Margaret Robinson (a Research Officer 1), and $2698 was expended on travel; and

- in the year ended 31 December 2001, $50,972 was expended on salaries and on-costs for Nirupama Verma, the originally nominated RO2, $3,160 on travel and $5,359 on materials."

The NHMRC would expect to approve any change to the Chief Investigators, but changes to research staff would be a matter for the chief investigators to manage, provided the project objectives were met. Under the conditions of award at that time, the assessment of whether the project objectives were met would be made when the project report was submitted.

The AFCB report went on to say:

"However, the project report is still not due on this grant as its three year duration only expired on 31 December 2002. It is not, therefore possible to assess the impact of the change in research officers on the project objectives.

Despite this, examination of the detailed financial records from the UNSW indicates that almost all of the salary recorded against this grant in 2000 was an internal transfer of salary for Catherine Robinson on 21 December 2000. This may indicate that no actual work was done on the project during the first calendar year, and raises questions about the adequacy of reporting requirements for NHMRC grants.

In addition, the UNSW's Senior Accountant Research sent a copy of the proposed statement of receipts and expenditure for the year ended 31 December 2000 to Dr He on 25 June 2001, seeking advice on any changes. These records are part of Attachment 5. No evidence has been provided that Dr He challenged this report. However, this request notes that no response will be taken as indicating no changes. This raises further questions about the adequacy of grant reporting processes.

Given the nature of the grant reporting requirements, and the fact that the documents from the UNSW indicate the involvement of accounting staff and agreement, or at least assumed agreement, of Dr He, it would not be possible to substantiate a case that Professor Hall misused funds for grant 113949 in a manner which implies an offence under the *Criminal Code*. However, there is still a possibility that the funds were not used in accordance with the requirements of the grant. This will only be known when the final report is received. This would be a matter from NHMRC to manage."

(b) The AFCB considered that the project work may not have been undertaken, and the funds may not have been used, in line with the *Conditions of Award for Project Grants Effective 1 January 2000*. However, while Clause 13 of the *Conditions of Award* at that time requires the Responsible Officer of the institution administering the grant (in this case the Director of the Research Office) to provide certification of expenditure for the previous calendar year by 30 June, Clause 26 only requires the Chief Investigator (in this case Dr He) to provide a report at the termination of the grant, and not annually. Consequently, it is not possible to provide a definitive answer to these questions until the final report is received.

(c) As there were different recollections and interpretations of the events surrounding this grant, the AFCB investigation focused on establishing as much factual evidence as possible from source documents. The documents collected and examined included the grant application, the letter of offer, notice of acceptance of offer, the Conditions of Award applicable at that time, acquittal documents and detailed financial records from the University of New South Wales' accounting system.

(d) A recommendation of the AFCB report was that "the NHMRC closely scrutinise the final report on grant ID113949 to determine whether this project was conducted in line with the application and grant agreement, and whether any variations are acceptable". The NHMRC will undertake a close review of the final report on this grant, which is currently due no later than 30 June 2004.

NHMRC's response to the AFCB report included advice that the NHMRC was in the process of developing advice for Administering Institutions to clarify issues surrounding the 'pooling of funds' for the purpose of managing grants, both in relation to salaries and consumables. Advice on this matter was sent to Research Administration Officers and Finance Officers of Administering Institutions on 1 October 2003.

Finally, the response to AFCB advised that the NHMRC is confident that annual reporting requirements and acquittal processes introduced under the Deed of Agreement in 2001, to replace the previous Conditions of Award - under which grant (App ID 113949) was offered - is a significant step forward in monitoring the progress of both the proposed research and the financial accountability of grants awarded under the various NHMRC grant schemes. Among other things researchers are now required to report progress on an annual basis rather than only provide a final report at the conclusion of the grant.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-083

OUTCOME 9: Health Investment

Topic: Continuation of Dr Clara He's Grant

Written Question on Notice

Senator Carr asked:

(a) Has the University of NSW formally contacted you, on or after 13 February 2003, with regard to the continuation or otherwise of Dr Clara He's research grant?

(b) Has the University indicated that it was proposing to return the balance (some $55,000) to NHMRC, on the basis of unsatisfactory progress with the research project associated with this grant?

(c) Has it indicated any other grounds for returning the money to you? What are these?

(d) Has the University resolved to the satisfaction of the NHMRC the issue of allegations that Dr He's NHMRC grant money was being misappropriated and/or misused by Professor Bruce Hall, or by anyone else?

(e) What has been the outcome of investigation of these allegations?

(f) Is it correct that NHMRC expected the report of the independent expert committee (the Brennan Report) would provide a finding on these matters?

(g) Is it the case that these matters did not form the subject of any finding of that report?

(h) Have these matters been resolved, or findings made, in any other forum or through any other process? Please provide details.

(i) Are you in receipt of correspondence from Dr He in which she states that progress on her research project has been seriously hampered by removal by the University of access to laboratory facilities (following her allegations against Professor Hall); and where she further states that the harassment and other difficulties that have occurred associated with the Hall matter have hindered her in making satisfactory progress with her research?

(j) Have you responded to Dr He? Please provide copies of any correspondence.

(k) Please also provide copies of correspondence between the University of NSW and the NHMRC, relating to Dr He's grant, dated June 5 2003 to the present.

Answer:

(a) Yes.

(b) No.

(c) Yes.
- Request for a carry-forward of funds for the increased amount to that originally requested and approved by NHMRC, has not been submitted by Dr He.
- A new Animal Ethics application for grant 113949 has not been submitted by Dr He.

(d) Yes - pending receipt of the final report for this grant, which is currently due no later than 30 June 2004.

(e) See answer to (d) above.

(f) Initially, yes.

(g) Yes, however on the advice of the Department of Health and Ageing's Audit and Fraud Control Branch (AFCB) the NHMRC is now awaiting receipt of the final report for grant ID113949 (see answer to (d) above). Upon receipt of the final report, the NHMRC may initiate a further investigation of the use of grant monies awarded to Dr He.

(h) Apart from the investigations conducted by the Department of Health and Ageing's Audit and Fraud Control Branch, there has been no other finding made by the Commonwealth.

(i) Yes - correspondence between UNSW and Dr He regarding laboratory access have been copied to the NHMRC by Dr He.

(j) Yes - Copies of letters of acknowledgement to Dr He are at Attachment A.

(k) Copies of correspondence between the UNSW and NHMRC relating to grant ID113949 since 5 June 2003 are at Attachment B.

[Note: the attachments have not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-084

OUTCOME 9: Health Investment

Topic: Findings of Brennan Report on allegations against Professor Bruce Hall

Written Question on Notice

Senator Carr asked:

(a) You stated at the June 2003 estimates hearing that the NHMRC helped draw up the terms of reference for the Brennan Inquiry at the University of NSW. Is that correct?

(b)
- (i) Did the Terms of Reference, in your view, empower the Inquiry to look into management of grant monies and related matters?
- (ii) Has the Inquiry, in its report, met that aspect of ToR?
- (iii) Otherwise, is the NHMRC satisfied that the Brennan Report adequately meets its Terms of Reference?

(c) Can you confirm that the report's findings include a number of findings of what amounts to academic misconduct, scientific misconduct and serious scientific misconduct?

(d) Do you believe that the Brennan Report is adequate in meeting the Terms of Reference from the point of view of the NHMRC's decision making process? If not, why not, and in what way or ways?

(e) After seeing the Brennan Report, did you decide to go ahead and conduct your own inquiry, or did you believe that this was not necessary?

(f) Have you been provided by the UNSW with a copy of the Vice-Chancellor's report and findings on the Brennan Report?

(g) What is your considered view about the findings made, and the actions recommended, by the Vice-Chancellor in his report?

(h) After consideration of this report, do you now believe that the NHMRC should conduct its own inquiry into the matters connected with the Bruce Hall case? If so, which matters?

(i) Do you intend to execute an inquiry? What is the timeline? What are the Terms of Reference?

(j) Has the University of NSW communicated with you formally about the findings of the Vice-Chancellor as contained in his report, and the implications for the suspended grant no. 209656?

(k) What was recommended to you?

(l) What action have you taken as a result, or do you propose to take?

Answer:

(a) Yes.

(b) (i) Yes.
(ii) Yes, see response to E04-083 (g).
(iii) Yes.

(c) Yes.

(d) Yes.

(e) The NHMRC did not believe a separate inquiry was warranted. On 1 October 2003, the NHMRC referred the matter of Grant ID209656 to the Department's Audit and Fraud Control Branch for consideration, who in turn referred the matter to the Australian Federal Police for investigation of possible criminal offences.

(f) Yes.

(g) The Report of the Vice-Chancellor, UNSW, was made under the aegis of the UNSW Enterprise Agreement and has no status in NHMRC decision-making processes.

(h) No.

(i) No.

(j) A copy of the Vice-Chancellor's Report was forwarded to the NHMRC by UNSW. The Vice-Chancellor's covering letter to the Report did not refer to implications for grant ID209656 that was terminated on behalf of the Commonwealth on 1 October 2003.

(k) See answer to (j) above.

(l) See answer to (j) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-085

OUTCOME 9: Health Investment

Topic: Management of Grant Monies

Written Question on Notice

Senator Carr asked:

(a)

(i) Has Professor Hall submitted a report, referred to on the Committee transcript from the 5 June Estimates hearing in 2003, on the NHMRC grant that he held at that time that was not suspended?

(ii) If so, have you examined it from the point of view management of grant monies, as recommended by the Department's Audit and Fraud Control Branch? What are your conclusions?

(iii) If not, when do you expect to receive the report from Professor Hall?

(iv) Can you undertake to advise the Committee on his acquittal of grant monies after you receive the report?

(b) You state on p.706 of the same transcript that you were expecting that the external inquiry into the Hall case – presumably you mean the one headed by Sir Gerard Brennan – to deal with "all unresolved matters from the matters that were considered unresolved by the UNSW Inquiry." You say that allegations of misuse of Dr Clara He's grant money by Professor Hall you thought would be considered by the Brennan Inquiry.

(i) Can you confirm that?

(ii) Did the Brennan Report actually deal with these matters?

(iii) Is it the case that the report did not deal with them?

(c) How do you propose to progress the matter, from the point of view of the NHMRC?

What action have you taken, or will be taken?

Answer:

(a)

(i) Dr He is the Chief Investigator (A) on grant ID113949 and is therefore responsible for providing the final report for this grant which is currently due no later than 30 June 2004.

(ii) See answer to (i) above.

(iii) See answer to (ii) above.

(iv) The NHMRC will advise the Committee on the acquittal of grant monies for grant ID113949 after it has been received from Dr He.

(b)

(i) Yes.

(ii) and (iii) See answer to E04-083 (g).

(c)

(i) Under the Conditions of Award, under which grant ID113949 was awarded (in 1999, with funding commencing in 2000), the management of grant funds is the responsibility of the Administering Institution, in this case UNSW.

(ii) The NHMRC wrote to UNSW and Dr He in August 2003 to remind both parties that UNSW is responsible for management of these matters. The letter further requested they work together to resolve the matters raised by Dr He and advise NHMRC of the outcome, including details of any accounting or other adjustments made in relation to grant ID113949.

An investigation into allegations of mismanagement of grant funds associated with grant ID113939 has been undertaken by the Department's AFCB. See answer to question E04-082.

The NHMRC will closely scrutinise the final report for grant ID113949 as per answer to question E04-082 (d) and E04-083 (g)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-086

OUTCOME 9: Health Investment

Topic: New Deed of Agreement with Grant Holders

Written Question on Notice

Senator Carr asked:

Can you provide a copy of the deed of agreement with grant holders, adopted by the NHMRC in 2003, replacing the previous conditions of award?

Answer:

The NHMRC introduced the Deed of Agreement (to replace the former Conditions of Award) in 2001. A copy of the current Deed is at Attachment A.

[Note: the attachment has not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-087

OUTCOME 9: Health Investment

Topic: Joint Statement with ARC

Written Question on Notice

Senator Carr asked:

On 5 June 2003, you told the Committee that the NHMRC was preparing a joint statement with the ARC on intellectual property, commercialisation and other issues.

(a) Have you finalised that statement? When will it be completed and released?

(b) Can you provide further information as to what issues the statement will cover?

Answer:

(a) A Joint AVCC/NHMRC Statement and Guidelines on Research Practice was published in November 1997. It replaced statements produced separately in 1990 by the NHMRC and the Australian Vice Chancellors' Committee (AVCC). The 1997 Statement exists to guide institutions in developing their own procedures and guidelines by providing minimum acceptable standards. Currently there is a review of this Statement by a Joint Working Group comprising representatives from the AVCC, the NHMRC and the Australian Research Council (ARC). The first round of consultations has been completed. A revised draft of the Statement will be the basis of further comprehensive consultations. It is anticipated that a final draft to be considered by the AVCC, the ARC and the NHMRC will be available in the next 12 months.

(b) The Joint Working Group is considering the following issues in its revision of the current Joint AVCC/NHMRC Statement and Guidelines on Research Practice – general principles; good research governance; responsible practice of research; conflict of interest; supervision and training; authorship; publication; records, data storage and retention; commercialisation; risk reduction; research misconduct; links to other codes, legislation and guidelines and monitoring and auditing.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-088

OUTCOME 9: Health Investment

Topic: UNSW Hall Case – Broader Implications

Written Question on Notice

Senator Carr asked:

(a) Does the NHMRC believe that its policy of relying on universities to administer, monitor and make decisions about NHMRC grants, and adjudicate in cases of alleged misconduct involving grant holders, is adequate and satisfactory?

(b) Will the NHMRC review its policies about, and approaches to, the manner in which it deals with universities in light of the Hall case?

(c) How will you amend your practices and policies?

Answer:

(a) At this time, yes. Institutions, including universities, administer National Health and Medical Research Council (NHMRC) research funding in accordance with the NHMRC Deed of Agreement. The Commonwealth, through the NHMRC, agrees to provide grant funding to institutions provided they execute the standard Deed of Agreement (see answer to E04-086). Institutions must comply with the legal obligations contained in the Deed to use the funds in support of the objectives of NHMRC Research Funding Schemes. As part of the Deed, Institutions agree to comply with the necessary guidelines and codes of practice including the Joint AVCC/NHMRC Statement and Guidelines on Research Practice. The Deed allows for external review for the purposes of auditing and evaluating research projects.

(b) See answer to E04-87(a). The same Joint Working Group is separately considering the range of approaches that could be used to deal with allegations of scientific misconduct. The Group will draft a discussion paper on this issue. This will be the basis of the first round of consultations on options for dealing with such matters.

(c) The NHMRC is awaiting the outcome of consultations by the Joint Working Group (see E04-88(b)) before determining what, if any, changes to its policies and practices are required.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2003-2004, 18 February 2004

Question: E04-119

OUTCOME 9: Health Investment

Topic: Research and Development

Written Question on Notice

Senator Stephens asked:

(a) Research and Development: According to "Access Economics" in 2000-01 only 0.4% of the Commonwealth's R&D budget went into Aboriginal Health. What was the percentage in 2001-02 and 2002-03?

(b) Do you consider that Aboriginal Health would benefit from greater R&D funding?

Answer:

(a) In the publication, "Exceptional Returns: The Value of Investing in Health R&D in Australia", Access Economics quotes expenditure on Aboriginal and Torres Strait Islander health as 0.4% of the total Commonwealth expenditure on health R&D in 2000-01. According to Access Economics, the data was derived from the Australian Bureau of Statistics (ABS) following a special data request. Information concerning Commonwealth expenditure on Aboriginal and Torres Strait Islander health in 2001-02 and 2002-03 could be obtained on request from the ABS. The NHMRC does not collate such data and is therefore unable to provide it. Alternatively, the information may be available from the Australian Institute of Health and Welfare (AIHW). The AIHW publishes a report "Expenditures on Health Services for Aboriginal and Torres Strait Islander People". A report covering the period 2001-02 is in development.

(b) In 2004, the NHMRC will provide over $10 million for Aboriginal and Torres Strait Islander related health research. The NHMRC is strongly committed to improving the health and welfare of Aboriginal and Torres Strait Islander people. To support its commitment, over the 2003-2005 triennium the NHMRC intends to grow the proportion of Indigenous health research to at least 5% of its total research funding.

The NHMRC has made substantial efforts to increase the quantum of funds directed to Aboriginal and Torres Strait Islander health research, as well as to ensure such research improves Aboriginal and Torres Strait Islander health. By carefully targeting research, the benefits of such research, in terms of real health gains, can be maximised.

In response to the Australian Government's National Research Priority of *Promoting and Maintaining Good Health*, the NHMRC will provide up to $7 million over five years to support research to improve the maternal, infant and childhood health of Aboriginal and Torres Strait Islander people.

The NHMRC has also established the Aboriginal and Torres Strait Islander Health Forum to provide strategic advice and improve the effectiveness of NHMRC's response to Aboriginal and Torres Strait Islander health issues.

Aboriginal and Torres Strait Islander health research is a priority for NHMRC. The NHMRC has made progress on a number of initiatives that represent advances in Aboriginal and Torres Strait Islander health research, and these advances raise the prospect for major improvements in health status in the years ahead. Attachment A outlines progress on several other NHMRC Aboriginal and Torres Strait Islander health research initiatives.

Examples of NHMRC research initiatives in Aboriginal and Torres Strait Islander health research

Centre for Clinical Research Excellence

The Aboriginal Health Council of South Australia, in partnership with Flinders University, will receive approximately $1.8 million over five years to establish Australia's first Centre of Clinical Research Excellence (CCRE) dedicated to Aboriginal and Torres Strait Islander Health. The Centre will focus on Aboriginal and Torres Strait Islander health research, capacity building and translation of research into practice and clinical applications.

Scholarships and Fellowships

The NHMRC funds Training Scholarships for Indigenous Health and Training Fellowships for Indigenous Health Research. The scholarships aim to expand the capacity of the Aboriginal and Torres Strait Islander health research workforce. The fellowships are offered to people who wish to make Aboriginal and Torres Strait Islander health research a significant component of their career.

Aboriginal and Torres Strait Islander Diabetes and Related Disorder Research Program

The Aboriginal and Torres Strait Islander Diabetes and Related Disorders Research Program provides funding for research focussing on:

- interventions which recognise the impact of diabetes over the lifetime of the sufferer, and involve the family as a focus;
- strategies that encompass education, physical activity, obesity and glycaemic control; and
- management of complications including heart disease, hypertension and related disorders.

International Collaborative Indigenous Health Research Partnership

In 2002, the Canadian Institutes of Health Research (CIHR), the Health Research Council of New Zealand (HRC) and the NHMRC entered into a Tripartite Agreement. One initiative of the Agreement is the International Collaborative Indigenous Health Research Partnership (ICIHRP) grant. The ICIHRP is intended to improve health for indigenous peoples through cross-country, multi-disciplinary and multi-sectoral research focused on the factors and processes that promote resilience. A call for Expressions of Interest for the ICIHRP will occur in June 2004.

NHMRC Road Map

The Aboriginal and Torres Strait Islander Research Agenda Working Group (RAWG) (a collaboration between the NHMRC and the Office of Aboriginal and Torres Strait Islander Health) developed the *Road Map: A strategic framework for improving Aboriginal and Torres Strait Islander health through research*. The *Road Map* was the culmination of a consultation process conducted to identify and gain consensus on national research priorities in Aboriginal and Torres Strait Islander health. A copy of the *NHMRC Road Map* is provided.

He report may be accessed at: http://www.health.gov.au/nhmrc/publications/pdf/r28.pdf

Aboriginal and Torres Strait Islander Health Research Working Committee

Building on previous work undertaken by the NHMRC in the 2000-2003 triennium, the Aboriginal and Torres Strait Islander Health Research Working Committee (ATSIHRWC), has been formed and will work in partnership with other policy working committees and funding scheme committees.

The primary responsibilities of the ATSIHRWC are to:

- promote and monitor the implementation of the *NHMRC Road Map*;
- consider and address the *NHMRC Road Map* research priorities not appropriately covered or addressed within existing processes;
- develop and implement the Tripartite Agreement for Indigenous Health Research;
- support the implementation of *Values and Ethics: Ethical Conduct in Aboriginal and Torres Strait Islander Health Research*;
- consider and address capacity building needs for Aboriginal and Torres Strait Islander researchers not appropriately covered or addressed within existing processes; and
- assist in the peer review of research funding applications related to Aboriginal and Torres Strait Islander health.