Community Affairs
Legislation Committee

Examination of Additional Estimates 2005-2006

Additional Information Received

CONSOLIDATED VOLUME 1

HEALTH AND AGEING PORTFOLIO

Outcomes: whole of portfolio,
Outcomes 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12

MAY 2006

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

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

Included in this volume are answers to written and oral questions taken on notice and tabled papers relating to the additional estimates hearing on 16 February 2006

*** Please note that the tabling date of 13 June 2006 is the proposed tabling date**

HEALTH AND AGEING PORTFOLIO

Senator	Quest. No.	Outcome 1: Population Health [contd]	Vol. 1 Page No.	Date tabled in the Senate*
Forshaw	65	Resourcing of ARPANSA	41	11.05.06
Forshaw	66	Response to ANAO report	42-48	11.05.06
Forshaw	67	Issue of licences	49	11.05.06
Forshaw	68	Reporting to Parliament - ARPANSA	50	11.05.06
McLucas	105	Hepatitis C infection and clearance rates	51	11.05.06
McLucas	106	Adverse reaction to Pertussis component of DTPa vaccine	52	11.05.06
Fielding	61, 62	RU486 - abortion statistics	53-54	11.05.06
		Outcome 2: Medicines and Medical Services		
Barnett	9, 11, 12, 13	Medicare funding of abortions	55-59	11.05.06
Fielding	59	Abortions statistics for RU486	60	11.05.06
Forshaw	76	Anticipated growth rate for the PBS over the next four years	61	11.05.06
Forshaw	80	Interdepartmental committee (IDC)	62	11.05.06
Forshaw	123	Meeting with Medicines Australia/Pharmaceutical Industry Working Group	63	11.05.06
Forshaw	70	EPC and Allied Health	64-66	11.05.06
Forshaw	81	Visudyne expenditure and eligibility	67	11.05.06
McLucas	83	Medicare spending	68	11.05.06
Forshaw	84, 85	Cataract procedures - implementation	69-70	11.05.06
McLucas	78	PBS cost of de-listing Cox Inhibitors	71	11.05.06
Forshaw	79	Growth in overall PBS script volumes	72	11.05.06
McLucas	82	Medicare Safety Net	73	11.05.06
McLucas	126	Registration levels – Medicare Safety Net	74	11.05.06
Forshaw	77	PBS Script volumes	75	11.05.06
McLucas	82	Medicare safety net	76	13.06.06*
McLucas	126	Registration levels – Medicare safety net	77	13.06.06*
		Outcome 3: Aged Care and Population Ageing		
Siewert	23	Carers and respite care	78-82	11.05.06
McLucas	34	Conditional Adjustment Payment (CAP) reporting deadline	83	11.05.06
McLucas	35	Kiwi Dale aged care bed licenses	84	11.05.06
McLucas	41	Indigenous Aged care - Troicas	85	11.05.06
McLucas	43	Residential aged care bed vacancies	86	11.05.06
McLucas	47	Aged care nurse practitioners	87	11.05.06
McLucas	49	Asset testing of new aged care residents	88	11.05.06
McLucas	50	Webster packs	89	11.05.06
McLucas	51	Resident classification scale reviews	90	11.05.06
McLucas	52	ACFI trial	91	11.05.06
McLucas	53	Commonwealth Carelink	92	11.05.06
McLucas	55	Home and Community Care (HACC) funding	93	11.05.06
Forshaw	86	Jackson Wells Morris	94	11.05.06
McLucas	110	Approved providers	95	11.05.06
McLucas	112	Closure of residential aged care facilities	96	11.05.06
McLucas	108	Certification fire standards	97	11.05.06
McLucas	109	Website – St David's sanction report 2001	98	11.05.06
McLucas	44	ACSAA funding	99	11.05.06
McLucas	38	Accreditation revoked	100	11.05.06

Media kit National tobacco campaign

http://www.quitnow.info.au/warnings/warnings.htm

Media kit 'Get moving' activity campaign

http://www.healthyactive.gov.au/getmoving/campaign.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-026

OUTCOME: Whole of Portfolio

Topic: GRANTS ISSUED TO HILLSONG CHURCH

Written Question on Notice

Senator Ludwig asked:

How many grants have you issued to Hillsong Church, its associated corporations and entities? List name, price and duration of funding by department.

Answer:

An examination of Departmental and Portfolio agencies' financial records, covering the past five years, has determined that no payments have been made to Hillsong Foundation, or its associated corporations and entities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006 16 February 2006

Question: E06-027

OUTCOME: Whole of Portfolio

Topic: DIRECTOR OF PUBLIC PROSECUTIONS (DPP)

Written Question on Notice

Senator Ludwig asked:

a) How many briefs have you forwarded to the DPP for 2001-02, 2002-03, 2003-04, 2004-05?
   i. How many briefs were returned without action, and how many were actioned?
b) For each year, what was the average time (as well as indicating the minimum and maximum time in each case) in which it took the DPP to:
   i. Bring charges against the accused party
   ii. Formally bring the matter to conclusion through either a verdict of guilty or not guilty, the entrance of a nolle prosequi or dropping the charges
   iii. Return the brief for no further action
c) Did the Department or agency forward any formal complaint to the DPP regarding the handling of the brief?
   i. If so, give details.
d) Did the Department or agency forward any informal complaints to the DPP regarding the handling of the brief?
   i. If so, give details.

Answer:

a) Four matters were forwarded to the DPP during 2001-02. One matter was forwarded to the DPP during 2002-03. No other matters have been forwarded to the DPP by the Department.
   i) Centralised records are not held and to gather this information would require a significant diversion of resources. The Department does not currently have the resources to answer this question.
b) The DPP responded to the Departments requests within two weeks of referral.
   i) Centralised records are not held and to gather this information would require a significant diversion of resources. The Department does not currently have the resources to answer this question.
   ii) Centralised records are not held and to gather this information would require a significant diversion of resources. The Department does not currently have the resources to answer this question.
   iii) Centralised records are not held and to gather this information would require a significant diversion of resources. The Department does not currently have the resources to answer this question.

c) No.

d) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-094

OUTCOME: Whole of Portfolio

Topic: STRENGTHENING MEDICARE

Hansard Page: CA 7

Senator McLucas asked:

How much was spent on Strengthening Medicare?

Answer:

$26.5 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2004-2005, 17 February 2005

Question: E05-010

OUTCOME 1: Population Health and Safety

Topic: PREGNANCY COUNSELLING SERVICES

Written Question on Notice

Senator Stott Despoja asked:

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

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

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

Answer:

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

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

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

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

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

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

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

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

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

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-015

OUTCOME 1: Population Health

Topic: AUSTRALIAN AND NEW ZEALAND THERAPEUTIC PRODUCTS AUTHORITY

Written Question on Notice

Senator Barnett asked:

a) Once the Australian and New Zealand Therapeutic Products Authority comes into operation what will be the status in Australia of a therapeutic good which at that time is registered in New Zealand but not in Australia?

b) Once the ANZTPA is in operation in registering a therapeutic good will any protocols imposed on the use of that good be necessarily uniform in both countries?

Answer:

a) The treaty obligations on both countries mean that at commencement of the Australian and New Zealand Therapeutic Products Authority (ANZTPA), all products that could be lawfully supplied in Australia or New Zealand can continue to be supplied in the country in which they were being supplied lawfully, for the duration of a specified transition period. In practical terms this means that in New Zealand, any product that has been granted a ministerial consent under section 20 of the Medicines Act, or provisional consent under section 23 of the Medicines Act, will be granted a transitional approval that applies in New Zealand only. These transitional approvals will be issued on the same terms and conditions as applied to that product under the Medicines Act. The Rules will provide for a three year period for which the transitional product approvals will be valid. During the transition period, all products will need to be granted a full product licence issued by the ANZTPA or, at the end of the transition period, the transitional approval will lapse. A full product licence will only be issued by ANZTPA following application and demonstration that the product meets all applicable standards of the joint regulatory scheme. An application for a full product licence could be made at any time during the transition period. If the application for a full product licence was successful, a product licence would be issued that would, in general, allow supply in both Australia and New Zealand.

b) ANZTPA will regulate the quality, safety and efficacy or performance of therapeutic products, and their manufacture, supply, import, export and promotion. The use of a licensed product will be governed by a range of other factors including (in Australia) State and Territory legislation governing the registration of medical practitioners.

The Agreement between the Government of Australia and the Government of New Zealand for the Establishment of a Joint Scheme for the Regulation of Therapeutic Products (the Treaty) allows for approvals (for example product licences) to apply differently in Australia and New Zealand.

The Treaty provides that either Australia or New Zealand may, by regulations made under their own implementing legislation, exclude or modify the application of the scheme in respect of a therapeutic product or class of therapeutic products. A country can only depart from the joint scheme under this provision if there are exceptional public health, safety, third country trade, environmental or cultural factors that affect that country.

Additionally an approval (for example a product licence) may apply in one country only, or apply differently in each country, where the regulator (ANZTPA) considers that it is desirable for the therapeutic product to be supplied in a different manner or subject to different requirements in each country. ANZTPA could only impose such conditions if there are differences in public health, safety, environmental or cultural circumstances between the two countries that make this necessary.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-016

OUTCOME 1: Population Health

Topic: RU486 (MIFEPRISTONE)

Written Question on Notice

Senator Barnett asked:

If mifepristone is registered either by the TGA or, after it comes into existence the ANZTPA, for use in abortions up to 9 weeks gestation what, if anything, would prevent a medical practitioner using it for second trimester abortions?

Answer:

The prescribing of medicines outside of its approved usage is commonly referred to as "off-label" use. The Commonwealth has no direct power or authority over the way in which individual doctors, or the medical profession in general, conduct their professional practice. This is regulated at a local level by the various State or Territory Medical Boards and by State or Territory legislation. Individual States and Territories are responsible for making and enforcing laws regarding the legality of abortions generally.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-017

OUTCOME 1: Population Health

Topic: ADVERSE EVENTS REPORTING

Written Question on Notice

Senator Barnett asked:

a) What arrangements does the TGA have in place in for receiving adverse events reports in relation to therapeutic goods registered for use in Australia?

b) What percentage of adverse events are believed to be actually reported to the TGA?

c) What arrangements does the TGA have with its counterparts in countries such as Britain, the United States and Canada for exchanging information on adverse events reports?

d) What information, if any, has the TGA received from it counterparts in other countries about fatalities and other adverse events reports following use of mifepristone to procure an abortion?

e) In evaluating the safety and efficacy of a drug what data must be provided by the applicant for registration to the TGA?

Answer:

a) Reports of suspected adverse reactions to medicines registered for use in Australia can be notified to the TGA's Adverse Drug Reactions Unit by mail, fax, telephone, email, or via an online form. Pre-paid mail-in cards ('blue cards') are made available to healthcare providers for such reports. Reports are accepted from doctors, pharmacists, other healthcare professionals, the pharmaceutical industry, and consumers. Reporting of suspected adverse reactions is mandatory for industry, but voluntary for other reporters. The TGA also operates a separate scheme for reporting suspected adverse reactions involving medical devices.

b) This percentage is unknown. The TGA receives around 10,000 medicine adverse reaction reports annually (9901 reports in 2005), which is one of the highest per capita reporting rates in the world.

c) The Adverse Drug Reactions Unit has formal arrangements with a number of countries, namely the United States, Canada, New Zealand and Singapore, for the exchange of information on adverse reactions to medicines. These arrangements include a regular series of videoconferences and teleconferences, as well as the ability to contact individual officers in other agencies on an as-needed basis. TGA also contributes to, and has access to the WHO database which records suspected adverse reactions to medicines occurring throughout the world. This program involves 76 actively participating countries.

d) The TGA has not received information about fatalities and other adverse events reports following use of mifepristone to procure an abortion from other medicine regulatory agencies. As mifepristone is not registered in Australia and no application for registration has been received this information has not been required.

e) Before a prescription medicine can be marketed in Australia, it needs to be included in the Australian Register of Therapeutic Goods. In order to register a new medicine in Australia a sponsor (usually a pharmaceutical company) needs to submit an application together with supporting data demonstrating quality, safety and efficacy.

The TGA evaluates the application and usually seeks the advice of an independent expert advisory committee, the Australian Drug Evaluation Committee (ADEC), before making a decision to approve or reject an application.

The TGA requires that when companies lodge applications for approval of medicines, they provide all studies related to that use, published or not, positive or negative, and all information relevant to the safety of the drug.

The sort of scientific data required to support approval of a product includes that arising from clinical trials. A clinical trial is an experiment conducted to assess the effectiveness and safety of a product or procedure in humans.

Further information on what constitutes adequate demonstration of quality, safety and efficacy is available on the TGA website through various guidance documents, including the Australian Regulatory Guidelines for Prescription Medicines and the European Union (EU) guidelines adopted in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-018

OUTCOME 1: Population Health

Topic: REGISTRATION OF RU486 (MIFEPRISTONE)

Written Question on Notice

Senator Barnett asked:

In the event that the TGA was able to consider an application for the registration of mifepristone for use to procure abortions up to 9 weeks in conjunction with the administration of misoprostol, how would such a use be registered assuming the manufacturer of misoprostol continues to oppose its use for procured abortion?

Answer:

An application to the TGA to register a medicine on the Australian Register of Therapeutic Goods (ARTG) can only be considered if made by a sponsor. Sponsors can only make applications to the TGA in respect of their own products.

If the intention is that use of a drug can only occur in the context of use with another product, then this combination use would have to be the subject of an application for registration.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-058

OUTCOME 1: Population Health

Topic: REGULATION OF THE USE OF PRODUCTS

Written Question on Notice

Senator Fielding asked:

In the estimates hearings, Ms Halton said that the TGA does not have the power to say how a particular drug is used, but that use of products is regulated by separate arrangements. What are those arrangements? Please provide details and a copy of any publication available on those arrangements.

Answer:

The regulation of medicines is a multifaceted process.

The TGA is involved in the evaluation, approval and supply of therapeutic goods by the person responsible for placing the goods on the market.

The National Drugs and Poisons Scheduling Committee (NDPSC) is involved in determining the retail supply channels of medicines according to the schedules listed in the Standard for the Uniform Scheduling of Drugs and Poisons. The responsibility for implementation of the scheduling decisions arising from NDPSC rests with States and Territories.

Once a medicine has been approved for supply by the TGA, it may be assessed by the Pharmaceutical Benefits Advisory Committee if listing on the Pharmaceutical Benefits Scheme is sought by the sponsor of the medicine.

The uses approved for marketing the product by the product's sponsor are stated in the Product Information (PI).

Prescribers may choose to utilise approved medicines for indications other than that which are listed in the PI if they consider that the clinical situation warrants such "off-label" use of the medicine. Regulation of "off-label" use of a medicine is dealt with as a professional practice matter via State registration authorities, or professional associations such as specialist medical colleges.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-099

OUTCOME 1: Population Health

Topic: NATIONAL DRUG STRATEGY ABORIGINAL AND TORRES STRAIT ISLANDER PEOPLES COMPLEMENTARY ACTION PLAN 2003-2006

Hansard Page: CA 79

Senator Crossin asked:

Because it [the Complementary Action Plan] runs from 2003-2006, I wanted to know if there were plans to review this; if so, what were those plans; if it is not going to be continued, why is that the case; and can I have a breakdown of the funds that have actually been committed over that three- to four-year period.

Answer:

The Ministerial Council on Drug Strategy has endorsed the extension of the National Drug Strategy Aboriginal and Torres Strait Islander Peoples' Complementary Action Plan (CAP) until 2009.

The purpose of the extension was to bring the CAP timeframe into line with the *National Drug Strategy 2004-2009*. Note that the *National Drug Strategy 2004-2009* already includes, within the identified priority areas, the implementation of the CAP.

There is no specific funding allocated to the implementation of the CAP. Rather the CAP provides guidance for action and investment by all State/Territory and Australian Government agencies involved in addressing Aboriginal and Torres Strait Islander Peoples' drug and alcohol issues.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-100

OUTCOME 1: Population Health

Topic: WEBSITE UPDATE

Hansard Page: CA108

Senator McLucas asked:

Is there a reason why [the following web pages] have not been updated since December 2003:

- Nutrition and healthy eating;
- Promoting healthy weight; and
- Promoting healthy weight about our work.

Answer:

The Department balances the need to make website material available to the public for new programs and initiatives with the need to regularly update existing material. Recently, work has focused on the HealthyActive website which features the *Building a Healthy Active Australia Initiative* and the National Obesity Taskforce's work addressing healthy eating and healthy weight.

There are a number of planned improvements to the existing web material including:

- Updating material as required and revision of the Nutrition and Healthy Eating pages to improve navigation. These changes are expected to be implemented by mid-2006.
- Adding further statistics and related links to the Promoting Healthy Weight pages.

A link to the HealthyActive website (www.healthyactive.gov.au) is featured on the Promoting Healthy Weight – About Our Work webpage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-101

OUTCOME 1: Population Health

Topic: HEPATITIS B INFECTIONS

Hansard Page: CA 110

Senator McLucas asked:

How many Australians are estimated to be infected with hepatitis B at the moment?

Answer:

In Australia, an estimated 90,000 to 160,000 people have chronic hepatitis B, representing a population prevalence of 0.5% to 0.8%.[1] The majority of people with chronic hepatitis B in Australia were born overseas, predominantly in countries of the Asia-Pacific region.[2]

The population rate of diagnosis of newly acquired hepatitis B declined from 2.2 per 100,000 (414 cases) in 2000 to 1.4 per 100,000 (275 cases) in 2004.[3]

1 O'Sullivan BG, Gidding HF et al. Estimates of chronic hepatitis B virus infection in Australia, 2000. *Aust N Z Public Health* (2004); 28(3):212-216.
2 Dore G, Wallace J et al. *Hepatitis B in Australia: responding to a diverse epidemic*. ACT – HBV: Advancing the clinical treatment of the hepatitis B virus (2006).
3 National Centre for HIV Epidemiology and Clinical Research. *Viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2005*. University of NSW, Sydney (2005).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-102

OUTCOME 1: Population Health

Topic: HIV/AIDS

Hansard Page: CA 110

Senator McLucas asked:

How many Australians are estimated to be infected with HIV/AIDS at the moment? If the figures is different from 16,000, please advise.

Answer:

At the end of 2004, an estimated 14,840 people were living with HIV/AIDS in Australia. Data for 2005 will become available in mid-2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-103

OUTCOME 1: Population Health

Topic: MORTALITY RATES HEPATITIS C, HEPATITIS B AND HIV/AIDS

Hansard Page: CA 110

Senator McLucas asked:

In 2004-2005, what was the mortality rate for hepatitis C, hepatitis B and HIV/AIDS?

Answer:

Mortality rates for hepatitis B and hepatitis C for 2004-2005 are not available.

For hepatitis B the latest available information is for 2003. The number of deaths with hepatitis B as the underlying cause of death in 2003 was 19.[4]

In 2002 it was estimated that since the beginning of the hepatitis C epidemic there had been 1,000 (range 750 to 1,200) cumulative deaths related to chronic hepatitis C infection.[5]

Surveillance data collection for HIV/AIDS reports deaths attributable to AIDS as annual and cumulative death rates. In 2004 there were 116 deaths attributable to AIDS. Up to 31 December 2004, a cumulative total of 6,590 deaths have been attributable to AIDS.[6]

4 Australian Institute of Health and Welfare

5 Hepatitis C Virus Projections Working Group. *Estimates and projections of the hepatitis C virus epidemic in Australia.* National Centre for HIV Epidemiology and Clinical Research, Sydney (2002).

6 National Centre for HIV Epidemiology and Clinical Research. *Viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2005.* University of NSW, Sydney (2005)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2005

Question: E06-104

OUTCOME 1: Population Health

Topic: HEPATITIS C LIVER BIOPSY

Hansard Page: CA 110

Senator McLucas asked:

How many people have a [liver] biopsy to see if they can be treated but are not sick enough [to access hepatitis C treatment under the Pharmaceutical Benefits Scheme]?

Answer:

It is not possible to accurately report on the number of people who undergo liver biopsy and do not proceed to treatment for hepatitis C. While information is available on the number of people in Australia who have a liver biopsy, the clinical reason for having a liver biopsy is not routinely collected. Liver biopsies can be undertaken to investigate a number of liver diseases, not solely for hepatitis C and not solely to determine eligibility for Pharmaceutical Benefits Scheme funded hepatitis C treatments.

The Minister for Health and Ageing, the Hon Tony Abbott MP, recently announced the removal of the liver biopsy requirement for eligibility to access hepatitis C treatment under the Pharmaceutical Benefits Scheme. The removal of this requirement will take effect from 1 April 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-001

OUTCOME 1: Population Health

Topic: AUSTRALIAN FEDERATION OF PREGNANCY SUPPORT

Written Question on Notice

Senator Stott Despoja asked:

(a) Is the Department aware that the Australian Federation of Pregnancy Support Services (AFPSS), which receives more than $200,000 per year in Federal Government funding, recently made a submission to a Senate inquiry (Inquiry into Therapeutic Goods Amendment (Repeal of Ministerial responsibility for approval of RU486) Bill 2005, submission 875) outlining its opposition to the abortion drug RU486 (the submission was made under its trading name of Pregnancy Counselling Australia)?

(b) Given that the Department has previously stated that the AFPSS is "funded to provide independent non-directive counselling for unplanned pregnancy" (Senate question number 457, tabled 15 April 2005), does the Department accept that the selective "evidence" contained in this submission illustrates a bias against abortion?

(c) If so, will the Department reconsider its decision to allocate public funding to the AFPSS and other false providers, which claim to – but do not – provide information on all three pregnancy options?

(d) Given the misleading information included in AFPSS's submission, does the Department acknowledge that more must be done to ensure information provided by pregnancy counselling organisations is based on reliable research provided by such reputable organisations as the World Health Organisation or the National Health and Medical Research Council?

Answer:

(a) The Department is aware of the submission made by the AFPSS under its trading name of Pregnancy Help Australia. A range of organisations funded by the Government made submissions to the Inquiry.

(b) The Department is committed to ensuring that the AFPSS meets the requirements of its funding agreement which is to provide independent non-directive pregnancy counselling.

(c) The Department accepts that the AFPSS and other non-government organisations have a right to put forward their policy positions to Parliamentary inquiries. No Australian Government funds are provided to the AFPSS to engage in advocacy.

(d) The Department encourages organisations it funds to employ a strong evidence-based approach to developing resources. In their service charter, AFPSS states that they provide "accurate and consistent information" to members of the community using their services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-002

OUTCOME 1: Population Health

Topic: PREGNANCY COUNSELLING

Written Question on Notice

Senator Stott Despoja asked:

(a) In a letter to Senator the Hon Kay Patterson dated 14 December 2005, in response to a letter from Senator Patterson on behalf of Dr Susie Allanson, the Health Minister claimed that "organisations funded by the Government are required to provide non-directive pregnancy counselling and information on the full range of options, including continuing the pregnancy or terminating". Following evidence outlined above about the AFPSS's position on abortion, does the Department concede the procedures for checking whether Government-funded organisations meet this criteria must be improved? Does the Department also acknowledge that regular checks, to ensure organisations in receipt of Government funds continue to meet these criteria, should also be introduced?

(b) What penalties, if any, are in place for organisations in receipt of Government funding which breach the criteria referred to by the Health Minister?

(c) Does the Department condone organisations in receipt of Government funding, such as the AFPSS, engaging in political lobbying, for example making submissions to Senate inquiries?

(d) What auditing practices are in place, if any, to ensure Government funding is not used for the purpose of such lobbying?

Answer:

(a) The Australian Federation of Pregnancy Support Services (AFPSS) is funded to provide non-directive pregnancy counselling. The Department has funding agreements with the organisations it funds for the provision of family planning and sexual and reproductive health services. Funding agreements are managed within a quality framework and organisations are responsible and accountable for the delivery of agreed outputs. Such outputs vary between organisations. Performance against these outputs is evaluated and measured through an agreed project plan and associated forecast expenditure plan. Organisations are required to report regularly and these progress reports are linked to payments. Progress reports must include an analysis of progress against the project plan, as well as financial statements.

(b) To continue to receive funding from the Australian Government, organisations are required to meet the terms of their funding agreements.

(c) The Department accepts that the AFPSS and other non-government organisations have a right to put forward their policy positions to Parliamentary inquiries. No Australian Government funds are provided to the AFPSS to engage in advocacy.

(d) The Department requires organisations funded for family planning and sexual reproductive health activities to provide regular reporting on their activities as part of the terms of their funding agreements. The AFPSS is required to provide six-monthly progress report which must include an analysis of progress against the agreed outputs in their project plan, as well as financial statements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-003

OUTCOME 1: Population Health

Topic: PREGNANCY COUNSELLING AUSTRALIA

Written Question on Notice

Senator Stott Despoja asked:

Last year, Pregnancy Counselling Australia distributed posters advertising its services (but omitting the fact that it is an anti-choice service which does not provide information about, or referrals for, abortion) to doctor's practices around the country.

(a) Was the Department aware of this at the time?

(b) Does the Department condone the practice?

(c) Is the Department aware of whether public funding was used in the production or distribution of these posters? If so, what is the Department's view on this?

(d) Considering organisations in receipt of Government funding are required to provide non-directive pregnancy counselling and information on the full range of options, including continuing the pregnancy or terminating, and Pregnancy Counselling Australia (PCA) has been proven to be an anti-choice service, will the Department engage in corrective advertising to doctor's practices to inform them about the true nature of PCA's services?

Answer:

(a, b, c, d)
The Department of Health and Ageing does not provide funding to Pregnancy Counselling Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-004

OUTCOME 1: Population Health

Topic: PREGNANCY COUNSELLING

Written Question on Notice

Senator Stott Despoja asked:

On 2 November, in response to confirmation from the Government that Section 75AT of the Trade Practices Act does not apply to pregnancy support and counselling services provided at no cost, Senator Nettle asked the Government what mechanisms it had "put in place to ensure consumers are protected from misleading and deceptive conduct by pregnancy counselling service providers". The Department answered that it "ensures the quality of services provided by organisations funded to deliver family planning and sexual and reproductive health through the overall quality framework, based on funding agreements" (question E05-159).

(a) Can the Department provide more information about this "overall quality framework"; and,

(b) Given the large number of complaints that have been received and compiled by organisations such as the Pregnancy Advisory Centre in Adelaide and the Fertility Control Clinic in East Melbourne, it is clear that this framework is not working. What, if anything, is the Department doing to rectify this?

Answer:

a) The Department requires organisations funded for family planning and sexual reproductive health activities to provide regular reporting on their activities as part of the terms of their funding agreements. Funding agreements are managed within a quality framework which requires organisations to be responsible and accountable for the delivery of agreed outputs. Such outputs vary between organisations. Performance against these outputs is evaluated and measured through an agreed project plan and associated forecast expenditure plan. Organisations are required to report regularly and these progress reports are linked to payments. Progress reports must include an analysis of progress against the project plan, as well as financial statements.
b) At the November 2005 Senate Estimates Hearings, the Department of Health and Ageing offered to investigate any complaints made to the Department by clients of

Australian Federation of Pregnancy Support Services (AFPSS) affiliated counselling services, regarding the quality of counselling and advice offered on the Helpline. To date, the Department has not received any complaints from clients.

The AFPSS has both a service and privacy complaints protocol in place, which is detailed in their Service Charter and which can be accessed via its web site: www.pregnancysupport.com.au.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-005

OUTCOME 1: Population Health

Topic: TELEPHONE INFORMATION SUPPORT AND COUNSELLING ASSOCIATION

Written Question on Notice

Senator Stott Despoja asked:

The Telephone Information Support and Counselling Association's (TISCA) states "Clients have the right to accurate and specific information about the services that a helpline offers. Clients have the right to expect that helplines are set up to provide a continuing, permanent service. Helplines must never exploit or abuse their Clients emotionally, financially, sexually, or in any other way". Given that there have been countless complaints of misleading behaviour by false pregnancy counselling providers and about the emotional impact this has had on many callers, does the Department believe all telephone helplines – including those run by pregnancy counselling organisations – should be regularly assessed by TISCA to ensure they do not breach this criteria? If not, why not? If so, will the Department move to ensure pregnancy counselling helplines are immediately assessed by TISCA?

Answer:

At the November 2005 Senate Estimates Hearings, the Department of Health and Ageing offered to investigate any complaints made to the Department by clients of counselling services, regarding the quality of counselling and advice offered on any Helpline. To date, the Department has not received any complaints from clients.

TISCA (now known as Helpline Australia) is not a regulatory body and does not have the capacity to conduct regular assessment of helplines. The Department is not aware of any other regulatory mechanisms.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-006

OUTCOME 1: Population Health

Topic: PREGNANCY COUNSELLING

Written Question on Notice

Senator Stott Despoja asked:

(a) In response to question on notice E05-158, the Department stated that "there are no qualification requirements for trainers delivering the AFPSS Counselling Skills Development Course for Pregnancy Workers". Does the Department consider this is appropriate, particularly given the sensitive nature of this work?

(b) In response to question on notice E05-158, the Department stated that "AFPSS has advised that they will provide a copy of the new training manual, which accurately reflects the current course, and all other resources when available". If the manual and other resources are now available, can the Department please provide me with copies of each.

Answer:

(a) The Australian Federation of Pregnancy Support Services (AFPSS) Counselling Skills Development Course for Pregnancy Workers is currently delivered by the Counselling Skills and Development Officer, who holds the following qualifications: Master of Education; Bachelor of Nursing; Bachelor of Education; and Certificate of Humanistic Psychology & Counselling, and has also commenced a PhD in Education on the subject of development, evaluation and education of counsellors.

The AFPSS is also currently reviewing its training materials and is still within the agreed timeframes of its funding agreement in regard to achieving status as a Registered Training Organisation.

(b) The AFPSS has advised that they anticipate providing the Department with the new training manual and curriculum by the middle of 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-019

OUTCOME 1: POPULATION HEALTH

Topic: REGULATORY GUIDANCE FOR RADIOACTIVE WASTE

Written Question on Notice

Senator Crossin asked:

On December 19 ARPANSA issued the REGULATORY GUIDANCE FOR RADIOACTIVE WASTE MANAGEMENT FACILITIES: NEAR SURFACE DISPOSAL FACILITIES; AND STORAGE FACULTIES - Draft for Public Comment - December 2005
a) Given you invited public comment on this how was it publicised?
b) Why is it not listed on the main ARPANSA media release page?
c) How widely was it sent out - to interested groups for example? Please provide a list of those to whom these guidelines were sent.
d) Why were these guidelines released only six days before Christmas?
e) What is the process of finalising the guidelines after public comments have been received?
f) What is the significance of the finalised document to your decision on issuing the licence for the OPAL reactor?

Answer:

a) The Draft was posted on the ARPANSA web site in the Drafts for Public Comment Section. The Department of Education, Science and Training (DEST), the Australian Nuclear Science and Technology Organisation (ANSTO), Greenpeace, Friends of the Earth, Australian Conservation Foundation, and members of ARPANSA's Radiation Health and Safety Advisory Council, Radiation Health Committee and Nuclear Safety Committee were advised by email that it was available for comment and how a copy could be obtained.
b) A media release was not issued.
c) In addition to posting on the website, DEST, ANSTO, Greenpeace, Friends of the Earth, Australian Conservation Foundation, and members of ARPANSA's Radiation Health and Safety Advisory Council, Radiation Health Committee and Nuclear Safety Committee were advised that it was available for comment. That is when the draft was completed.The comments received will be reviewed and the draft amended as appropriate. The responses to the comments will be published together with the revised guidance.There is no direct relationship between the guidelines and the decision on the operating licence for OPAL.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-020

OUTCOME 1: Population Health Topic: REGULATORY GUIDANCE FOR RADIOACTIVE WASTE

Written Question on Notice

Senator Crossin asked:

Meaning of references in guidelines to "the time period during which institutional controls may be relied upon".
a) In ARPANSA's draft guidelines for the dump regular mention is made of "active institutional control of the site" - what is meant by this term?
b) How long do you anticipate "active institutional controls" will last at the site?
c) The guidelines refer to "a time period during which institutional controls can be relied upon"? How do you anticipate how long they can be relied upon?

Answer:

a) "Active institutional control" means the implementation of measures that ensure on-going knowledge that the site has been used for the disposal of radioactive waste and may include restrictions on access to the site or restrictions on future site use prohibiting construction or digging on the site. The nature of restrictions may vary for different sites and for different stages after closure. Restrictions that apply during operation of the facility might change post-closure.
b) Periods of 100 to 300 years are commonly recommended for shallow ground burial facilities. The institutional control period would depend on the nature of the radionuclides, in particular their half life, their total activity and activity concentration and potential future uses for the site.
c) The term of institutional control should be such that higher activity wastes decay to low levels before the end of the institutional control period. Engineering controls and requirements to restrict access to higher activity wastes should be designed to last for the institutional control period.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-022

OUTCOME 1: Population Health

Topic: REGULATORY GUIDANCE FOR RADIOACTIVE WASTE

Written Question on Notice

Senator Crossin asked:

The draft EIS for the South Australian national repository prepared for DEST by PPK in 2002 (extract below) speaks of the environmental management required once it's operational. It includes references on page 308 to "drains from operational areas where radioactivity is handled to an evaporation pond within the repository compound".
Given your concerns about the dangers to wildlife is an open pond out of the question or might such a pond be managed to minimise this and to actually stop the pond attracting wildlife especially in an arid region?

Answer

If a shallow ground waste disposal facility proposes to use an open pond for evaporation of drainage water the environmental impact of this operation would need to be assessed as part of the Environmental Impact Statement (EIS).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-060

OUTCOME 1: Population Health

Topic: THE MORNING-AFTER PILL (POSTINOR-2)

Written Question on Notice

Senator Fielding asked:

f) Is the Department concerned about media reports this year (eg. The Sunday Times WA, 8 January 2006) that girls as young as 15 years old, and in previous years reports girls as young as 13 years old, are buying the morning-after pill Postinor-2 over the counter at pharmacies?

g) If not, why not?

h) What is the Department doing to address this problem?

i) What conditions did the Department place on dispensing Postinor-2 when it was approved by the Department for over-the-counter sale?

j) What statistics are kept on the sale of the morning-after pill?

k) Please provide me with statistics of unit sales for 2002, 2003, 2004 and 2005 by state and territory.

Answer:

a & b) Yes.

c) A survey of jurisdictional representative members of the National Drugs and Poisons Schedule Committee was undertaken in February 2006. This survey and an earlier survey in March 2004 following the previous media reports, however, did not identify any formal complaints to any relevant State or Territory authorities concerning such sales that would support the media claims.

d) The decision to make levonorgestrel tablets for emergency contraception (Postinor-2) available as a Pharmacist Only Medicine through inclusion in Schedule 3 of the *Standard for the Uniform Scheduling of Drugs and Poisons* (SUSDP) was made by the National Drugs and Poisons Schedule Committee. It is a State/Territory legislative requirement that the pharmacist be involved in the supply of Schedule 3 medicines such as Postinor-2 through the provision of professional advice on its use.

e & f) The distributor of Postinor-2 in Australia, Schering Pty Ltd, in response to the Therapeutic Goods Administration's request for sales statistics to enable this question to be answered, advised that it regards sales data as commercially sensitive and wishes to retain this information in confidence.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-008

OUTCOME 1: Population Health

Topic: PREGNANCY COUNSELLING

Written Question on Notice

Senator Stott Despoja asked:

(a) Can the Department provide figures for the amount of funding provided to pregnancy counselling services, including direct and indirect funding and a breakdown by organisation, for 2004-05?

(b) When available, can the Department provide figures for the amount of funding provided to pregnancy counselling services, including direct and indirect funding and a breakdown by organisation, for 2005-06?

(c) Can the Department provide figures for the amount of funding which will be allocated to pregnancy counselling services in the 2006-07 Budget, including direct and indirect funding, and a breakdown of funding by organisation.

(d) Is the Department aware of plans to allocate additional funding to a national pregnancy counselling hotline, in this year's Budget?

Answer:

(a) In 2004-05 the Australian Government committed funding of $16.78 million to a range of sexual and reproductive health services. This comprised $15.4 million for Family Planning Organisations and $1.378 million directly to other non-government organisations.

Of the organisations funded directly by the Australian Government, the only pregnancy counselling service is the Australian Federation of Pregnancy Support Services (AFPSS). In 2004-05, direct funding of $245,580 was provided to the AFPSS.

The Australian Government decided on 29 March 2004 that funding for all Family Planning Organisations would be incorporated with the Public Health Outcome Funding Agreements (PHOFAs) for the period 2004-05 to 2008-09. It is the responsibility of the state and territory governments to allocate funds to meet the agreed outcomes under the terms of the PHOFAs.

(b) The 2005-06 funding provided to the AFPSS will be available following the end of the financial year. The Department will provide these figures to the Committee by the end of July 2006.

[Secretariat note: these figures will be included and tabled with answers relating to Budget estimates 2006-07]

As the PHOFA funding is broadbanded it is not possible to disaggregate the amount spent by states and territories in delivering the nationally agreed outcomes. However the funding levels of $15.4 million to Family Planning Organisations that applied in 2004-05 indicate the level of expected ongoing commitment.

(c) The Department is not able to provide the amount of funding which will be allocated to pregnancy counselling services in the 2006-07 Budget.

(d) The Australian Government announced on 2 March 2006 that it is introducing a new Medical Benefits Schedule (MBS) item and a new Pregnancy Support Helpline, to provide non-directive counselling and support for women who have an unintended pregnancy or who are uncertain about continuing with a pregnancy.

These new measures are expected to cost $51.1 million over four years. The Helpline is expected to cost $15.5 million over four years. Medicare-funded counselling is expected to cost $35.6 million over four years. The MBS item will commence on 1 November 2006 and the Helpline is expected to be operational by December 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-014

OUTCOME 1: Population Health

Topic: RU486 AND IMPLANON TRIAL

Written Question on Notice

Senator Barnett asked:

a) Could all documents relating to the approval for the clinical trial of RU486 (mifepristone) for controlling bleeding in connection with Implanon be supplied, including but not limited to the application for the trial, endorsement by an institutional ethics committee and consent forms for participants in the trial?

b) Before approval was given for this trial what evaluation of the safety, quality and efficacy of the mifepristone being used in the trial was conducted and by whom? What were the results of this evaluation?

c) Where was the mifepristone for this trial imported from?

d) In what factory was it produced?

e) What information was provided from the supplier of the mifepristone as to the quality of the product and the manufacturing standards of the factory in which it was produced?

f) What controls were in place to ensure that all the mifepristone imported for this trial is accounted for?

Answer:

a) and b) The trial referred to was conducted under the Clinical Trial Notification Scheme. The Clinical Trial Notification scheme is administered by the Therapeutic Goods Administration (TGA).

The trial proposal and associated documentation are reviewed by an ethics committee or committees with jurisdiction at the proposed trial site(s), and an endorsement provided to the sponsor which forms part of the notification sent to the TGA. Only ethics committees that have notified themselves to the Australian Health Ethics Committee (AHEC), a sub-committee of the National Health and Medical Research Council (NHMRC), and are operating according to the AHEC's guidelines are acceptable as endorsing committees for the purposes of the Clinical Trial Notification Scheme.

The Clinical Trial Notification also involves endorsements by the trial sponsor, principal investigators, and "approving authorities" (persons with the authority to allow entry to the trial site(s)).

The Clinical Trial Notification form is then "notified" to the TGA along with the prescribed fee, and thus creates the exemption required for authority to supply an unapproved medicine in the context of the clinical trial.

The TGA does not approve the trials.

Documents cannot be released as specified under (c).

c) and d) This information is considered commercially confidential and would not normally be released. Information provided to the TGA concerning the use of unapproved therapeutic goods in relation to clinical trials is treated as confidential within the constraints of Section 61 of the *Therapeutic Goods Act 1989* which prescribes certain circumstances in which information may be released.

The *Freedom of Information Act 1982* (FOI Act) also governs access to information. Section 27 of the FOI Act requires that consultation occur between the TGA and the owner of the information prior to release of that documentation.

In addition, the *Privacy Act 1988* places limits on the disclosure of personal information by parties in possession or control of records. Such parties cannot disclose personal information about an individual to a person, body or agency other than the individual concerned except under certain circumstances.

e) The TGA did seek and was provided with evidence that the manufacturer had a current Good Manufacturing Practice certificate for its premises. Such a certificate is an internationally recognised way of enforcing Good Manufacturing Practice principles on sites of manufacture of drugs around the world.

f) Enforceable conditions applied to the import permission for this drug stated, among other things, that supply was permitted solely for the context of the clinical trial; under no circumstances may any of the drug be used for abortifacient purposes; and that any remaining drug must be disposed of in accordance with any applicable State and Territory law.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-021

OUTCOME 1: Population Health

Topic: REGULATORY GUIDANCE FOR RADIOACTIVE WASTE

Written Question on Notice

Senator Crossin asked:

In issuing the OPAL reactor construction licence it seems that grave doubts were expressed about the current state of knowledge of the radiation dangers to wildlife especially in "environments where non-human species are likely to be those most exposed, as may be the case for a waste repository" and "I consider that there is not yet an established radiation protection system for non-human species that can be regarded as international best practice.."

a) What is ARPANZA's understanding of the current state of knowledge in this area?
b) Wouldn't the radiation dangers to wildlife be especially concerning where local lizards, birds and other animals and plants are part of the bush tucker food chain?
c)Your concerns seems to be at odds with Mr Davoren comments on 8 December 2005 at the ARPANSA FORUM ON THE OPAL LICENCE According to the transcript he noted "Aborigines are very concerned about the contamination of bush foods" "But we may do an EIS which says it's all okay". Can you so easily say an EIS would say it is all OK?
In ARPANSA's draft Regulatory Guidance for radioactive waste management facilities - in section 3.1 Protection of the Environment again you imply much more work needs to be done on the uncertain effects of radiation on animals in the environment of the dump.

3.1 Protection of the Environment
With respect to any anticipated, significant discharges to the environment from the operation of a radioactive waste store, pending further developments in international guidance in this area, the applicant should undertake a screening assessment of doses to non-human biota in the vicinity of the store using one of the internationally currently accepted screening tools.

d) Can you explain what you are asking applicants to do here?
e) Will it require ground breaking research covering local species or something more generic?
f) You basically say the goal posts for the protection of non-human biota are likely to change - what problems does that pose for you and applicants?

Answer:

a) Several national and international authorities are developing guidance on the protection of non-human species in the environment from the effects of ionizing radiation and whilst there are differences there are also many similarities in their approaches. Most agree that the endpoint should be the protection of species from significant impacts and that this outcome is best ensured by restricting daily doses. While detailed assessments would need site specific assessments several countries have developed screening tests which

give an indication if there is the potential for a problem.

b) The impact of contamination of plants and animals which are part of 'bush tucker food' would be assessed as part of the impact on humans.

c) The consequences for humans of eating contaminated food are reasonably well understood. Specific surveys of 'bush tucker' for the region would have to be undertaken and concentration factors determined. This would be part of an Environmental Impact Statement (EIS) and application for a siting licence.

d) In order to assess the potential impact on species it would be first necessary to do a study of species in the site area with a particular emphasis on species which might be especially at risk. Potential doses to these species would then be estimated.

e) The international system for radiation protection can be expected to include specific and explicit approaches for consideration of effects on non-human biota, modeling, reference to flora and fauna etc. But if the simple screening calculation shows radiation doses to relevant flora and fauna are well below these levels there would not be the need for detailed and specific record. If this were not the case the operator would have to undertake detailed studies of the site to establish that species are not at risk.

f) Whilst there is no agreed international methodology for assessing environmental impact several well developed methodologies are available. There may be some changes in emphasis and direction but it is likely that any changes would be more evolutionary than revolutionary. This may require the operators to undertake more site specific assessments than might otherwise be required if a well established system were in place.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-007

OUTCOME 1: Population Health

Topic: PREGNANCY COUNSELLING

Written Question on Notice

Senator Stott Despoja asked:

There are reports the Government is considering establishing a national hotline for pregnancy counselling. Can the Department provide any details about this proposal (please include information about the proposed establishment date, and tendering process, if applicable)?

Answer:

The Australian Government announced on 2 March 2006 that it is introducing a new Medical Benefits Schedule (MBS) item and a new Pregnancy Support Helpline, to provide non-directive counselling and support for women who have an unintended pregnancy or who are uncertain about continuing with a pregnancy.

These new measures are expected to cost $51.1 million over four years. The Helpline is expected to cost $15.5 million over four years. Medicare-funded counselling is expected to cost $35.6 million over four years. The MBS item will commence on 1 November 2006 and the Helpline is expected to be operational by December 2006.

The Helpline will assist women in areas where access to appropriate general practitioner and allied health professional services may be limited. It will also benefit those who need assistance after hours, and provide a quality service option for those who prefer to remain anonymous or to receive counselling and advice in a non-clinical setting. Partners, who will not be eligible for the MBS item, will also be able to receive advice from the Helpline.

The Helpline will be established through an open tender process. It will be conducted with advice from an advisory committee comprising representatives of relevant professional associations.

The tender process will comply with the Commonwealth Procurement Guidelines. A Tender Evaluation Committee comprising officers from Department of Health and Ageing will be established to assess and rate tenders against specific criteria. The committee will be supported by technical advisers from relevant professional bodies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-069

OUTCOME 1: Population Health

Topic: FAMILY PLANNING ORGANISATIONS

Written Question on Notice

Senator Adams asked:

Please advise whether the "Family Planning Organisations" will be receiving any funding from the recently announced $60 million that will go to pregnancy counselling services, and if not then which organisations are to get that funding?

Answer:

See answer to E06-007

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-065

OUTCOME 1: Population Health
Topic: RESOURCING OF ARPANSA

Written Question on Notice

Senator Forshaw asked:

The ANAO released a Performance Audit on ARPANSA in March 2005 (Report No 30, 2004-05). The Report found that ARPANSA lacked sufficient resources at its inception and "the size and scope of the regulatory function were underestimated during its planning and implementation. The number of sources was four times more than planned, and the number of facilities nearly three times more." (See Key Finding 6)

a) Why were these estimates so wrong?

b) How does ARPANSA know that all sources and facilities have now applied for a licence?

c) What has been done to increase and improve the resources available to ARPANSA?

Answer:

a) With regard to sources, it was not until the larger organisations using sources invested in establishing centralised inventories that an accurate number could be known. With regard to facilities, the increased number is principally an artefact of the definition of facilities in the ARPANS legislation.

b) It is not possible to know for certain. Australian Radiation Protection and Nuclear Safety Agency (ARPANSA) continues to take appropriate steps to draw attention to the requirements of legislation.

c) The ANAO report itself referred to increased resources being devoted to regulation by ARPANSA.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-066

OUTCOME 1: Population Health Topic: RESPONSE TO ANAO REPORT

Written Question on Notice

Senator Forshaw asked:

In its response to the ANAO Report ARPANSA stated that "A formal review has been established to recommend changes to business processes and to oversee their implementation. The review will act upon all the ANAO recommendations."

a) What has happened with the review? Please provide a detailed summary of any progress made in implementing the ANAO recommendations.

b) What effect has resourcing the review had on the day to day operations of ARPANSA?

Answer:

a) The review will conclude on 31 March 2006. A summary of progress for each recommendation is attached.

b) Resources for the review were drawn from ARPANSA's regulatory and corporate areas and required funding that would otherwise have been devoted to ARPANSA activities across the board. As a general result, lower priority activities have been delayed.

Action TAKEN/to be taken by ARPANSA
in response to the ANAO recommendations AS AT 10.03.2006

Recommendation No.1	The ANAO recommends that ARPANSA's Corporate and Branch plans address key priorities and strategies for delivering regulatory outcomes. This would include clearer articulation of objectives and prioritisation of those objectives.	ARPANSA has prepared a strategic regulatory statement which sets out the fundamental ways that ARPANSA seeks to achieve regulatory outcomes for inclusion in the newly prepared corporate plan. The paper was considered by the RRCC and has been circulated for comment to all licence holders. This policy paper has been incorporated into the ARPANSA 2005/08 Corporate Plan. A more strategic Regulatory Business Plan has been prepared. **COMPLETED**
Recommendation No.2	The ANAO recommends that ARPANSA develop key performance indicators and targets for the regulatory function that inform stakeholders of the extent of compliance by controlled persons, and of ARPANSA's administrative performance.	The revised Regulatory Branch Business Plan includes KPIs which will be monitored and reported so as to provide information about licence holder and ARPANSA performance. KPIs attributed to licence holder performance will be consulted with all licence holders before being finalised. **IN PROGRESS**
Recommendation No.3	The ANAO recommends that ARPANSA enhance its risk management framework to identify risks to achievement of regulatory outcomes, mitigation strategies to manage those risks, residual risks, and a process of systematic monitoring of residual risks and their treatment.	ARPANSA has conducted risk management workshops with all staff to identify operational risks. These risks have been analysed, sorted in risk priority order and will be regularly reviewed to monitor risk mitigation strategies. ARPANSA has also identified five strategic risks which will be the subject of ongoing review by the Executive Board. This risk framework will be systematically monitored by the Executive Board, the internal auditor and the Audit Committee. **COMPLETED**
Recommendation No.4	The ANAO recommends that ARPANSA strengthen management of the potential for, or perceptions of, conflict of interest, in accordance with legislative responsibilities, by: • ensuring adequate documentation of all perceived or potential conflicts of interest;	ARPANSA is reviewing and preparing to 're-launch' its policy and procedures for managing conflict of interest by mid-March 2006. With regard to regulation of its own use of sources and facilities, to increase transparency, ARPANSA has written to the Victorian State radiation regulator seeking agreement to take part in inspections and assessments of ARPANSA's own activities. The Victorian Department of Human Services has agreed and

	• taking action to better manage the conflict of interest arising from its regulatory role in respect of its own sources and facilities; and • implementing and ensuring compliance with instructions issued.	an MoU is being prepared. The broader potential of conflict of interest where ARPANSA provides advice to its licence holders on radiation safety, participates on accreditation panels, such as NATA, in relation to licence holders, as well as regulating those licence holders, is also being addressed. **IN PROGRESS**
Recommendation No.5	The ANAO recommends that ARPANSA: • review and assess performance against customer service standards in its customer service charter; and • systematically action and report on all complaints received.	ARPANSA is working to ensure a consistent approach to the handling of complaints across the regulatory and service functions of ARPANSA within the ARPANSA Quality Management System. A complaints register has been established for Regulatory Branch, which is being updated, analysed and will be reported on in the Annual Report. The Customer Service Charter will be reviewed and forwarded to all licence holders annually, together with a feedback form. The first feedback survey will be undertaken in March 2006, so as to allow the results to be included in the 2006 Annual Report. **ESSENTIALLY COMPLETED**
Recommendation No.6	The ANAO recommends that, in order to provide assurance that cost recovery is consistent with better practice and government policy, ARPANSA: • develop a policy framework to guide its cost recovery arrangements; and • have sufficiently reliable data, and analysis, on cost elements to support management decisions on cost recovery—such analysis should include the alignment of fees and charges with the	ARPANSA prepared a draft policy framework on cost recovery. The paper has been reviewed by the RRCC and has been circulated to all licence holders for comment and a cost recovery policy has been adopted. On 01/11/2005 ARPANSA installed software to record regulatory activity in relation to individual licence holders. This activity is being costed and will form the basis for a more transparent recording of regulatory costs by licence holder and by source and facility licence. ARPANSA will follow the Government Cost Recovery Guidelines as much as possible, bearing in mind that those Guidelines exempt cost recovery from other Government agencies. The cost recovery policy was discussed with licence holders at the Licence Holder Forum on

	costs of regulation for particular groups of clients or types of licences, to the extent that this is cost-effective.	23/02/2006. **COMPLETED**
Recommendation No.7	The ANAO recommends that ARPANSA enhance guidance to applicants to better reflect the requirements of the ARPANS Act and Regulations and, in particular, to provide guidance on the statutory matters that the CEO must take into account.	The current information pack to applicants has been reviewed and rewritten into 3 packs; sources, prescribed radiation facilities and nuclear installations. The first two have been circulated for comment by licence holders and have been finalised. The nuclear installation pack has been circulated for comment by 24/03/2006 to ANSTO and DEST. **ESSENTIALLY COMPLETED**
Recommendation No.8	The ANAO recommends that ARPANSA introduce appropriate systems to ensure its application processing complies with the requirements of the ARPANS Act and Regulations.	Now that the application information packs have been finalised, a template has been developed for ARPANSA officers assessing applications. Out for comment by Regulatory Branch staff. **ESSENTIALLY COMPLETED**
Recommendation No.9	The ANAO recommends that ARPANSA enhance its licence application assessment processes by ensuring that: • guidance to staff explicitly addresses specified statutory matters that the CEO must take into account; and • regulatory assessment reports provided to the CEO on each application explicitly address the extent to which an application addresses these matters..	Implementing ANAO recommendations 7 and 8 as above will result in this recommendation being completed. **ESSENTIALLY COMPLETED**
Recommendation No.10	The ANAO recommends that ARPANSA develop a risk-based decision-making process for the use of additional licence conditions. This would require clear procedures and documentation addressing, inter alia, why and how conditions will be applied, monitoring of	The use of additional licence conditions is now relatively rare as the licensing of pre-existing activities has been completed. A manual risk assessment of licence holders is currently underway. This work will become automated following the development of Module 2 of RMIS. New licence applications have risked assessed licence conditions imposed if necessary.

	those conditions, and their costs and benefits.	Existing licences are being reviewed and licence conditions are specified in relation to individual licences. **COMPLETED**
Recommendation No.11	The ANAO recommends that ARPANSA develop and implement a central database for the management of applicant and licence-holder information.	A consultant has been engaged to develop the Regulatory Management Information System. The user specifications have been completed. The RMIS will be developed in 3 modules; module 1 on licence administration by 30/04/2006, module 2 on regulatory control by 30/06/2006 and module 3 providing an internet link between licence holders and ARPANSA by 30/09/2006. **IN PROGRESS**
Recommendation No.12	The ANAO recommends that ARPANSA monitor the timeliness of licence approvals against service standards, and report on this in its annual report. .	Timeliness of licence approvals will be monitored by RMIS and will be reported in future Annual Reports. **ESSENTIALLY COMPLETED**
Recommendation No.13	The ANAO recommends that ARPANSA develop and implement an explicit, systematic and documented overall strategic compliance framework that: • identifies and articulates the purpose, contribution, resourcing and interrelationships of the various compliance approaches; • is based on systematic analysis of the risk posed by licensees and the sources and facilities under their management; and • targets compliance effort measures in accordance with assessed licensee risk..	In order for ARPANSA to develop an explicit, systematic and documented overall strategic compliance framework, it must firstly address ANAO recommendations 7, 14, 15, 16 and 18. These recommendations will be addressed by 15.03.2006, after which time the overall compliance framework will be documented. **IN PROGRESS**
Recommendation No.14	The ANAO recommends that, to facilitate licensee understanding of and compliance with their	Reliance on the Licence Handbook has been reduced for new and revised licences by including conditions explicitly on the licence. The Licence Handbook will be revised and

	obligations, ARPANSA revise or replace the Licence Handbook to address identified weaknesses.	retained as a general reference source for licence holders to be informed about the Act, Regulations and licence holder rights and obligations. The licence handbook is no longer referred to in specifying licence conditions. **COMPLETED**
Recommendation No.15	The ANAO recommends that ARPANSA enhance its reporting guidelines by: • implementing procedures to keep the guidelines up to date; • specifying the level of supporting evidence required in reports; • providing feedback to licensees on reports; and • seeking client feedback on its guidelines.	The reporting guidelines have been revised and enhanced. There will be further consultation with licence holders on the new guidelines at the second Licence Holder Forum. **COMPLETED**
Recommendation No.16	The ANAO recommends that ARPANSA monitor compliance by licensees with reporting requirements.	Recent quarterly reports clearly report on licence holder reporting compliance, and will continue to do so. **COMPLETED**
Recommendation No.17	The ANAO recommends that ARPANSA develop standard procedures, for the consideration and assessment of reports, that address: • processes to provide assurance that licensee reports are appropriately assessed and acted upon; and • the collation and monitoring of reported information for risk management purposes.	RMIS will ensure licence holder reports are monitored and considered for the purposes of the risk assessment register. **IN PROGRESS**
Recommendation No.18	The ANAO recommends that ARPANSA establish a systematic, risk-based framework for compliance inspections that includes: • an integrated inspection program based on systematic and transparent assessment of the relative risks of	Pending completion of the RMIS, ARPANSA is undertaking a manual risk assessment of licence holders. Post RMIS this process will be automated and will be used to specify discretionary licence conditions and inspection schedules. A rating scale will be introduced for assessing licence holder compliance and common report format and terminology will be introduced for

	facilities and hazards; • inspection reporting procedures that clearly assess the extent of licensee compliance with licence conditions; • recording of report findings in management information systems, to facilitate future compliance activity, and analysis of licence compliance trends; • accountable and transparent procedures for discretionary judgements, where compliance inspections vary from standard procedures; and • reporting on ARPANSA's performance in conducting inspections.	consistent appraisal and recommendations to the CEO. Reporting of ARPANSA and licence holder performance will be undertaken. Any licence holder performance measures will be consulted with licence holders. RMIS will include an continually reviewed risk register. ARPANSA performance will be reviewed through RMIS and will be reported in future Annual Reports. **IN PROGRESS**
Recommendation No.19	The ANAO recommends that, in order to provide greater assurance that failures to meet licence conditions are dealt with and reported appropriately, ARPANSA: • develop internal systems, policies and procedures to support a consistent approach to defining non-compliance and breaches; • have a robust framework to support a graduated approach to enforcement action; and • maintain a database of non-compliance and enforcement actions taken and their resolution.	A matrix of responses to breaches of licence conditions, the Act and Regulations has been consulted within ARPANSA and with all licence holders. The purpose of the matrix is to provide a consistent and appropriate graduated regulatory response, which is known to all licence holders. This document will be reviewed on an ongoing basis. The regulatory action taken will be recorded on RMIS and monitored for effect. **ESSENTIALLY COMPLETED**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-067

OUTCOME 1: Population Health
Topic: ISSUE OF LICENCES

Written Question on Notice

Senator Forshaw asked:

The ANAO Report noted that "ARPANSA has not rejected any applications for a licence. However it has imposed special conditions on all licences issued." (Key finding 31) and "Some of these conditions appear to be significant aspects of recognised international best practice which, is a necessary requirement for a licence." (Key finding 32)

a) What is the meaning of "special conditions"?

b) Is the issue of licences with special conditions regarded as appropriate?

c) Are the licences and special conditions ever reviewed? If so how often?

Answer:

a) Licence conditions are established by the Act and Regulations and the CEO may impose conditions at the time of issuing a licence or subsequently. Conditions imposed by the CEO have been generic to types of sources and facilities or have been 'special' as applying only to a particular licensee.

b) As stated in the ARPANSA response (ANAO report, page 94) "*ARPANSA does not accept the suggestion in the ANAO report that additional licence conditions were used to address fundamental deficiencies in applications. Rather the purpose of these additional licence conditions was to provide an impetus to the licence holders to upgrade the plans and arrangements to modern standards and to encourage a culture of continuous improvement in relation to particular licence holders*."

c) Where licence conditions imposed by the CEO require certain actions to be undertaken, the licence conditions are reviewed and may be removed following completion of those actions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-068

OUTCOME 1: Population Health

Topic: REPORTING TO PARLIAMENT - ARPANSA

Written Question on Notice

Senator Forshaw asked:

The ANAO Report noted that "ARPANSA has reported only one designated breach to Parliament. This is notwithstanding that there have been a number of instances where ARPANSA has detected non-compliance by licensees." (Key finding 52)
a) Why has only one breach been reported (up to the time of the ANAO Report)?
b) Have any further breaches been reported to Parliament since the ANAO Report?
c) What is the difference between a "breach" and "non-compliance"?
d) What steps have been taken to ensure that all breaches and/or instances of non-compliance are reported to Parliament in future?
e) Will ARPANSA report on any past breaches/non compliance that should have been previously reported? If not, why not?

Answer:

a) As noted in the ARPANSA response (ANAO report page 94) "*ARPANSA operates on the basis of providing procedural fairness to any controlled person whose interests are affected by a preliminary view that they are in breach of the Act or Regulations. Hence, initial views about 'non-compliance' are put to controlled persons, including the factual basis upon which that view of possible 'non compliance' has been formed. Very often, the controlled person will respond with acceptable actions and in those circumstances, whilst a breach may have occurred, the rectification of that breach usually means that subsequent enforcement action is not required.*"

   At the time of the ANAO report ARPANSA did not report rectified breaches to the Parliament.

b) Subsequent to the ANAO report, ARPANSA reports all breaches determined by the CEO and potential breaches with significant safety implications and potential breaches of administrative matters that are under review in its quarterly reports to the Parliament.

c) The act only refers to "breach" of licence conditions.

d) See answer b) above.

e) As noted in a) above, the breaches not reported to the Parliament concerned issues where appropriate rectification action had been taken by the licence holder.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-105

OUTCOME 1: Population Health

Topic: HEPATITIS C INFECTION AND CLEARANCE RATES

Hansard Page: CA 111

Senator McLucas asked:

(a) Of those 240,000 people who are currently infected [with hepatitis C]: from a population health point of view, by how much do you bring that down before the infection rate actually starts to diminish, in an epidemiological sense? If you could point me in the direction of a study that looks at that sort of data it would be interesting.

(b) If every one of those 240,000 people were able to access the treatment, and did, what clearance of the virus would you get, given the fact that there are different types of the virus and effectiveness?

Answer:

(a) In 2004 an estimated 259,570 people had been infected with hepatitis C. Based on the figures provided in the 2005 Annual Surveillance Report approximately 25% of people exposed to hepatitis C naturally clear their infection.[7] In 2004, an estimated 194,260 people had ongoing hepatitis C infection in Australia.

One recent study has modelled the impact of treatment rates on hepatitis C prevalence.[8] A tenfold increase in treatment levels would be required to reduce new hepatitis C infections by 2% to 3%. Unlike other infectious diseases, there is a time delay between when the infection is acquired and when treatment is appropriate. Acute hepatitis C is generally asymptomatic and therefore infection is often detected some time after initial exposure. In addition, treatment is usually only offered to, or considered by, patients who experience symptoms of advanced chronic hepatitis C some years following the infection.

(b) There are up to six genotypes of hepatitis C. Genotypes 1, 2 and 3 are widely distributed in Western countries. In Australia it is estimated that around 55% of people who are currently infected with hepatitis C have genotype 1, while 35% have genotypes 2 and 3 and less than 10% have the remaining genotypes 4, 5 and 6.

Treatment efficacy, that is a sustained reduction in viral load, is around 80% for genotypes 2 and 3, and 45% for the remaining genotypes.

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7 National Centre in HIV Epidemiology and Clinical Research. *HIV/AIDS, viral hepatitis and sexually transmissible infections in Australia Annual Surveillance Report 2005.* National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales, Sydney.

8 Dore G and Day C. Can Hepatitis C Treatment Play a Role in Prevention? *5th Viral Hepatitis Australasian Conference Handbook and Abstracts.* Australasian Society for HIV Medicine, Sydney NSW (2006).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-106

OUTCOME 1: Population Health

Topic: ADVERSE REACTION TO PERTUSSIS COMPONENT OF DTPA VACCINE

Hansard Page: CA116

Senator McLucas asked:

How rare is it [for children to have an adverse reaction to the pertussis component of DTPa]?

Answer:

A report published in *Communicable Diseases Intelligence* (Vol 29, No 3, 2005, pp 248-262) published by the Department of Health and Ageing showed that between 1 January 2004 and 31 December 2004, there were 303 reports of adverse events following immunisation with a diphtheria, tetanus, acellular pertussis (DTPa) containing vaccine. Only 18 (6%) of these reported a serious side effect occurring after a DTPa vaccine. The most common reaction after receiving DTPa vaccine was injection site reaction (176 of 237 reports, or 60%). The report concluded that "the consistently low reporting rate of serious adverse events demonstrate the high level of safety of vaccines in Australia".

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-061

OUTCOME 1: Population Health

Topic: RU486 - ABORTION STATISTICS
Written Question on Notice

Senator Fielding asked:

I note that the Institute has recently published the report "Use of routinely collected national data sets for reporting on induced abortion in Australia", that the report relies on data from Medicare and the National Hospital Morbidity Database and that it will be preparing annual reports.
a) Would the introduction of abortion drug RU486 make it impossible for the Institute to accurately estimate the numbers of abortions each year in Australia?
b) What difficulties would be faced in preparing a report where RU486 was one available method of abortion?
c) How would the Institute collect statistics on the number of RU486 abortions?

Answer:

(a) There is no single authoritative or complete data source on terminations of pregnancies in Australia. This means that it is not possible to give a precise number of terminations each year.

The methodology currently used to estimate the number of abortions each year reflects the legislative, clinical and health financing settings in which abortions may occur. To the degree that RU486 might add additional considerations to this methodology, these would be taken into account in estimating the number of abortions. It is not possible to comment further without knowing the legislative and clinical context in which RU486 may be used.

(b) See (a).

(c) See (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-062

OUTCOME 1: Population Health

Topic: RU486 - ABORTION STATISTICS

Written Question on Notice

Senator Fielding asked:

I note that a number of politicians in the RU486 debate said they wanted better abortion statistics, so that the nature of the problem could be better understood. What changes are needed to help collection of better, more detailed and more accurate statistical data on abortions?

Answer:

There is no single authoritative or complete data source on terminations of pregnancies in Australia. An estimate of the number of induced abortions each year can be derived from the National Morbidity Casemix Data Set (NMDS) and Medicare Benefits Schedule claims data. These data do not include information on the circumstances around induced abortion, nor on clinical outcomes.

Data is not uniformly collected across all jurisdictions on a number of factors associated with clinical procedures including abortion. Information on diagnosis, reason/indication, complications, socioeconomic characteristics of the patient, category of medical practitioner undertaking a procedure, related services and risk factors are not gathered as a matter of course.

Decisions on what to include in health data collections are a complex balance between clinical utility, patient privacy, administrative overhead, compatibility with other data collections and secondary uses. Before changes could be made to data collected about clinical services including abortion services, investigations would need to be taken about the full range of intended uses of data, in close consultation with patients, providers and other stakeholders and taking into account the costs and benefits of definitional and system changes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-009

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE FUNDING OF ABORTIONS

Written Question on Notice

Senator Barnett asked:

a) Which items on the Medicare schedule are applicable to procured abortions?

b) For each of these items how many procedures were carried out in the last 12 month period for which statistics are available?

c) For each of these items how much money was paid in Medicare benefits in the last 12 months, 2 year and 3 year period for which statistics are available? At what gestation was the abortion procured (an estimate noting the weeks gestation would be acceptable)?

d) If any of these items also cover procedures other than procured abortion what are these procedures and what was the known or estimated number of such procedures carried out in the last 12 month period for which statistics are available?

e) Is a Medicare benefit payable for a procured abortion which is performed in violation of the law of the state or territory in which it is performed?

Answer:

a) Medicare Benefits Schedule (MBS) item 35643 - evacuation of the contents of the gravid uterus by curettage or suction curettage. This item covers terminations but will also apply to those situations where there is a missed abortion (the foetus has died but not been expelled) and trophoblastic disease which is an abnormality of the placenta and in some cases is cancerous. The MBS item should not include those situations where the women has had a miscarriage or where the woman is not pregnant such as scraping the lining of the womb to try to reduce heavy menstrual bleeding.

   MBS item 16525 - management of second trimester labour, with or without induction, for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease.

b) In the calendar year 2005, item 16525 was claimed 770 times and item 35643 was claimed 69,383 times; although it is not possible to ascertain which of these services were for procured abortion.

c) The amount of Medicare benefits for items 16525 and 35643 over the last three years is shown at table 1 below.

Table 1:Medicare Expenditure by calendar year for MBS items 16525 and 35643

Item	Medicare Benefits 2003	Medicare Benefits 2004	Medicare Benefits 2005
16525	$118,000	$126,000	$148,000
35643	$10,361,000	$10,531,000	$10,262,000

The descriptor for item 16525 provides for the management of labour in the second trimester. Medicare data does not contain detailed information on the week of gestation that the procedure is performed.

d) Items in the MBS generally describe the medical procedure rather than the reason for the procedure. Where they do provide a reason, there is usually more than one, so no distinction can be made as to why a procedure was performed.

In the case of item 35643, which covers the clinical procedure of evacuating the contents of the gravid uterus, the procedure is identical whether it is performed for a termination, or for a missed abortion (where the fetus has died in-utero). In this regard, there is no distinction between the two reasons for the procedure. The Department is unable to estimate the numbers for each type of service.

Similarly, there is no distinction between the possible reasons for performing item 16525, which covers the clinical management of second trimester labour, with or without induction, for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease.

e) No. For a termination to be funded through Medicare it needs to be performed in accordance with state and territory laws.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-011

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE FUNDING OF ABORTIONS

Written Question on Notice

Senator Barnett asked:

a) According to The Consultative Council on Obstetric and Paediatric Mortality and Morbidity's Annual Report for the Year 2003 incorporating the 42nd Survey of Perinatal Deaths in Victoria in 2003 a total of 219 abortions were performed at 20 weeks gestation or later. Of these 103 were for "psychosocial reasons". Are abortions at 20 weeks gestation or later for "psychosocial reasons" covered by Medicare?

b) The Report also states that the remaining 116 post 20 week abortions were performed because a congenital abnormality was diagnosed. Are abortions at 20 weeks gestation or later for eugenic reasons covered by Medicare?

c) The Report states that in 41 (35.3%) of these abortions the baby survived outside the womb for some time less than 6 hours. Are abortions at 20 weeks gestation or later which result in the live birth of a child covered by Medicare?

d) The report notes that there has been an increase in the number of babies surviving after abortion due to the use of vaginal misoprostol to induce labour. Is the Department aware of any statement by the manufacturer/distributor of misoprostol on its use in procuring abortion?

Answer:

a), b) and c)

Medicare benefits for induction and management of labour in the second trimester (up to 6 calendar months or 26 weeks) is restricted to intrauterine foetal death, gross foetal abnormality or life threatening maternal disease. There is no Medicare item for second trimester terminations outside these restrictions.

Questions of clinical practice arising in relation to terminations are matters for state and territory health authorities and the appropriate professional medical authorities. It is a matter for the doctor's clinical judgment as to whether a patient's condition meets the second trimester requirements.

d) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-012

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE FUNDING OF ABORTIONS

Written Question on Notice

Senator Barnett asked:

Is a Medicare benefit payable for a procedure when that procedure uses a drug "off-label"?

Answer:

It is not illegal for a medical practitioner to prescribe a medicine to treat a condition outside the use for which it has been registered by the Therapeutic Goods Administration (known as "off-label" prescribing). Where a drug is listed on the Pharmaceutical Benefits Schedule (PBS) for specific indications, no subsidy is payable if the drug is used for other purposes. If a drug is listed without a restriction to specific indications, then a PBS subsidy will be paid for all scripts.

A Medicare benefit is payable for clinically relevant professional services rendered by qualified medical practitioners according to the items listed in the Medicare Benefits Schedule.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-013

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE FUNDING OF ABORTIONS

Written Question on Notice

Senator Barnett asked:

a) If mifepristone were to be registered in Australia for use in procured abortions up to 9 weeks gestation, would such a procedure be covered by any existing Medicare item?

b) If no, then what steps would need to be taken to establish a new item for such a procedure?

c) If such an item were established how much benefit is likely to be payable under this item compared to existing Medicare items which cover procured abortion?

Answer:

a) There are no specific procedures in the Medicare Benefits Schedule that would cover the use of mifepristone for abortion.

b) There are standard procedures in place for adding or amending items in the Medicare Benefits Schedule. In the case of new procedures or technologies, these are developed in consultation with the relevant professional association following consideration of their safety, effectiveness and cost-effectiveness, generally by the Medical Services Advisory Committee, and approval by Government for public funding.

c) As mifepristone has not been registered by the Therapeutic Goods Administration, the Department has not considered Medicare coverage in this context.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-059

OUTCOME 2: Medicines and Medical Services

Topic: ABORTIONS STATISTICS FOR RU486

Written Question on Notice

Senator Fielding asked:

a) If RU486 is approved for use in Australia, how would the department be able to provide statistics or estimates of the number of abortions carried out each year in Australia?

b) Would RU486 abortions be recorded in some way for statistical purposes?

Answers:

a) Current methodologies used to estimate the numbers of terminations of pregnancy each year in Australia have generally used a combination of data from the Hospital Morbidity Data Set (in-hospital data) and the Medicare Benefits Schedule (out of hospital data). These reflect the settings in which terminations of pregnancy currently occur. Should the range of settings change, the methodology to collect these data would need to be refined.

b) It would be premature to comment on whether or how this might occur as this drug is not currently registered in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-076

OUTCOME 2: Medicines and Medical Services

Topic: ANTICIPATED GROWTH RATE FOR THE PBS OVER THE NEXT FOUR YEARS

Hansard Page: CA 35

Senator Forshaw asked:

What is the anticipated growth rate for the cost of the Pharmaceutical Benefits Scheme for the next four years, commencing with 2005-06?

Answer:

The following information is based on the Pharmaceutical Benefits Scheme (PBS) Forward Estimates at Portfolio Additional Estimates 2005-06 (9th February 2006):

Average Annual Growth over Four Year Period 2005-06 to 2009-10: 8.0%

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-080

OUTCOME 2: Medicines and Medical Services

Topic: INTERDEPARTMENTAL COMMITTEE (IDC)

Hansard Page: CA 40

Senator Forshaw asked:

Which departments are represented on the IDC?

Answer:

The following Departments are represented on the IDC that has been looking at PBS issues:

- Department of Prime Minister and Cabinet
- The Treasury
- Department of Finance and Administration
- Department of Health and Ageing
- Department of Industry, Tourism and Resources.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-123

OUTCOME 2: Medicines and Medical Services

Topic: MEETINGS WITH MEDICINES AUSTRALIA/PHARMACEUTICAL INDUSTRY WORKING GROUP

Hansard Page: CA 45

Senator Forshaw asked:

Has the department had any meetings with Medicines Australia recently and particularly following meetings in the US - say, since the last round of estimates - about the generic pricing policy and/or the evergreening provisions in the free trade agreement?

Answer:

The Department has had no meetings with Medicines Australia concerning generic medicines pricing policy or the Australia US Free Trade Agreement amendments to the *Therapeutic Goods Act 1989* since the November 2005 Senate Estimates Hearings.

The Department has participated in two meetings of the Pharmaceutical Benefits Scheme Subgroup of the Pharmaceutical Industry Working Group, of which Medicines Australia is a member, on 21 November 2005 and 19 December 2005, at which generic medicines pricing policy was discussed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-070

OUTCOME 2: Medicines and Medical Services

Topic: EPC AND ALLIED HEALTH

Hansard Page: CA 72

Senator Forshaw asked:

a) For the six months since July 2005, could you provide details of the number of services by month for each of the EPC items 720, 722, 724, 726, 728 and 730?
b) What proportions of patients with an EPC plan were referred on to an allied health services professional or dentist?
c) For each of the six months since July 2005, could you provide services by months again for each of the CDM, or chronic disease management items? Those numbers are 721, 723, 725, 727, 729 and 731?
d) What proportions of patients with a CDM plan were referred on to an allied health services professional or a dentist?
e) Finally, is there any data about how many patients received five allied health services and/or three dental services?

Answer:

a) Table 1 provides the number of services (by date of service) by month for each of the Enhanced Primary Care (EPC) items 720, 722, 724, 726, 728, 730 for the period 1 July 2005 to 31 December 2005.

Item Number	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Total
720	10,107	8,443	6,525	6,353	0	0	31,428
722	136	168	159	151	0	0	614
724	11,316	12,823	11,669	11,260	0	0	47,068
726	97	76	111	77	0	0	361
728	83	89	94	84	0	0	350
730	644	461	421	420	0	0	1,946
Total	22,383	22,060	18,979	18,345	0	0	81,767

Table 1: Based on date of service, including data processed to the end of December 2005.

No services were provided in November or December 2005 as these items were removed from the Medicare Benefits Schedule on 31 October 2005 (replaced by new Chronic Disease Management (CDM) items 721 – 731 from 1 July 2005).

b) To be eligible for a Medicare rebateable allied health or dental care service, a patient must have an EPC plan. Under the old items an EPC plan meant items 720, 722 or 730.

As Medicare Australia only captures data on services actually received and claimed from rebate claims, the Department of Health and Ageing cannot provide information on the proportion of patients with an EPC plan that were referred by their GP for Medicare rebateable services. The Department can, however, provide the following information on the proportion of patients with an EPC plan (items 720, 722, and 730) who also received allied health or dental care services during the period 1 July to 31 December 2005.

	% of patients receiving allied health or dental care services							
Care plan completed in	% of patients not receiving any allied health or dental services in this period	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Total
Jul-05	64%	19%	11%	3%	1%	1%	0%	100%
Aug-05	67%	0%	18%	9%	3%	1%	1%	100%
Sep-05	69%	1%	1%	16%	9%	3%	1%	100%
Oct-05	72%	1%	1%	1%	15%	9%	2%	100%
Total	67%	6%	9%	7%	6%	3%	1%	100%

Table 2: Based on date of service, including data processed to the end of January 2006.

Months referred to are the month during which the EPC plan was completed; and the month during which the patient received their first allied health or dental care service.

Table 2 shows that approximately 33% of patients who received EPC planning services using items 720, 722 or 730 between 1 July 2005 and 31 December 2005 also received Medicare rebateable allied health or dental care services during that period.

It should be noted that patients being managed under an EPC plan are not only referred for Medicare rebateable allied health and/or dental care services. GPs may refer patients to other publicly funded services, such as hospital outpatient clinics, the More Allied Health Services program or the Better Outcomes in Mental Health Care Program. Some patients may access services under private health insurance arrangements.

c) Table 3 provides the number of services (by date of service) by month for each of the relevant CDM items 721, 723, 725, 727, 729 and 731 for the period 1 July 2005 to 31 December 2005.

Item Number	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	Total
721	35,751	56,413	54,871	57,404	71,615	53,982	330,036
723	7,197	13,256	15,319	17,873	24,765	19,661	98,071
725	2,175	2,473	2,868	3,970	12,038	11,514	35,038
727	923	1,099	1,123	1,396	4,081	3,805	12,427
729	36	41	48	56	140	121	442
731	211	526	613	296	1,084	967	3,697
Total	46,293	73,808	74,842	80,995	113,723	90,050	479,711

d) To be eligible for a Medicare rebateable allied health or dental care service, a patient must have an EPC plan. Under the new CDM items an EPC plan means items 721 and 723, or item 731.

As Medicare Australia only captures data on services actually received and claimed from rebate claims, the Department of Health and Ageing cannot provide information on the proportion of patients with an EPC plan that were referred for Medicare rebateable services. The Department can, however, provide the following information on the proportion of patients with an EPC plan (CDM items 721 and 723 and 731) who also received allied health or dental care services during the period 1 July to 31 December 2005.

	% of patients receiving allied health or dental care services							Total
Care plan completed in	% of patients not receiving any allied health or dental services in this period	Jul-05	Aug-05	Sep-05	Oct-05	Nov-05	Dec-05	
Jul-05	53%	17%	16%	6%	3%	3%	2%	100%
Aug-05	54%	1%	19%	15%	6%	4%	2%	100%
Sept-05	53%	1%	1%	20%	16%	7%	2%	100%
Oct-05	56%	1%	1%	0%	19%	17%	4%	100%
Nov-05	66%	1%	1%	0%	0%	19%	13%	100%
Dec-05	82%	1%	1%	1%	0%	0%	14%	100%
Total	62%	3%	5%	7%	7%	9%	7%	100%

Table 4: Based on date of service, including data processed to the end of January 2006

Months referred to are the month the care plan was completed and the month the first allied health or dental service was received.

Table 4 shows that approximately 38% of patients who received CDM services using items 721 and 723 together, or 731 between 1 July 2005 and 31 December 2005 also received Medicare rebateable allied health or dental care services during the same period.

It should be noted that patients being managed under an EPC plan are not only referred for Medicare rebateable allied health and/or dental care services. GPs may refer patients to other publicly funded services, such as hospital outpatient clinics, the More Allied Health Services program, or the Better Outcomes in Mental Health Care Program. Some patients may access services under private health insurance arrangements.

e) Of the 86,819 patients that received Medicare allied health or dental care services in the 6 months from 1 July 2005 to 31 December 2005:

- 13,140 patients received five Medicare rebates for eligible allied health services;
- 272 patients received three Medicare rebates for eligible dental care services; and
- 25 patients received five allied health services and three dental care services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-081

OUTCOME 2: Medicines and Medical Services

Topic: VISUDYNE EXPENDITURE AND ELIGIBILITY

Hansard Page: CA 44

Senator Forshaw asked:

a) Do you have any figures for the spending of the current year to date?

b) In this review has consideration been given to expanding the eligibility criteria? Is that one of the things that has been looked at?

Answer:

a) Expenditure for the program from 1 July 2005 to 31 December 2005 was $11.2 million.

b) The objective of the review of Visudyne therapy was to provide Government with advice on the appropriateness, effectiveness and efficiency of the funding arrangements. The review did not examine eligibility criteria. The eligibility criteria for the Visudyne program are in line with the recommendations of the Medical Services Advisory Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-083

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE SPENDING

Hansard Page: CA 47

Senator McLucas:

Is it possible for you to give us on notice, the total spending on Medicare for the calendar year 2005?

Answer:

The total spending on Medicare for calendar year 2005 was $10.615 billion.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-084

OUTCOME 2: Medicines and Medical Services

Topic: CATARACT PROCEDURES - IMPLEMENTATION

Hansard Page: CA 49/50

Senator Forshaw asked:

a) When was the decision made to restrict Medicare benefits to admitted hospital patients for cataract surgery? Who made the decision?

b) How was the decision communicated to the profession, hospitals, and the general public?

c) Were there any special efforts made to communicate this decision to organisations – for instance, senior citizens, nursing homes, retirement centres, groups like that – comprising those that may be specifically affected more than most by the decision?

Answer:

a) Following consultation with the Australian Medical Association (AMA) and relevant professional medical organisations, the Minister for Health and Ageing, on 12 September 2005, approved a recommendation to proceed with the restriction of approximately 60 items to in-hospital procedures, effective 1 November 2005. These items included items for cataract surgery.

b) The Department includes all changes to the Medicare Benefits Schedule (MBS) in the Summary of Changes at the front of the Medicare Benefits Schedule Book. It is usual practice for the AMA and professional medical colleges to disseminate detailed information about item description changes and claiming arrangements to their membership.

   The Department advises Medicare Australia of proposed changes to the MBS approximately six weeks before publication so that staff can be prepared for client questions.

c) No. More than 95% of these procedures are performed on admitted hospital in-patients. For the vast majority of these services, there was no change to funding arrangements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-085

OUTCOME 2: Medicines and Medical Services

Topic: CATARACT PROCEDURES

Hansard Page: CA 49/50

Senator Forshaw asked:

a) How many cataract procedures in Australia are done on non-admitted patients?

b) What percentage of patients in the last year who had their surgery done as an outpatient received reimbursement under the Medicare safety net?

Answer:

a) For the 2005 calendar year there were 107,475 cataract procedures billed to Medicare. 3,092 (or 3%) of these were performed on non-admitted patients.

b) For the 2005 calendar year there were 3,092 cataract services performed on non-admitted patients. Of this group, 35% (or 1,067 patients) received additional benefits from either or both of the Medicare safety nets.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-078

OUTCOME 2: Medicines and Medical Services

Topic: PBS COST OF DE-LISTING COX INHIBITORS

Hansard Page: CA 37

Senator McLucas asked:

Could a figure be put on the reduction in script numbers for Cox inhibitors?

Answer:

The Cox inhibitors group of drugs includes Celecoxib, Rofecoxib and Meloxicam. PBS script volumes for all Cox II inhibitors have almost halved with a 45% reduction since Rofecoxib (Vioxx®) was delisted from the PBS on 30 September 2004. Vioxx's delisting followed a voluntary worldwide withdrawal of this drug by the manufacturer.

Table 1 shows the average monthly volumes of each drug in the Cox II inhibitors group for a 12 month period before and after the delisting of Rofecoxib (Vioxx®) (see note below).

Table 1

	Average Monthly Volume prior to delisting of Rofecoxib (12 months to 30 Sept 2004)	**Average Monthly Volume after delisting of Rofecoxib** (12 months after 1 Feb 2005)	**Average Monthly Volume Change**	**Percentage Change**
CELECOXIB	245,773	155,363	- 90,410	-37%
MELOXICAM	85,540	155,282	69,741	82%
ROFECOXIB	232,885	82	- 232,803	-100%
Total	564,198	310,726	- 253,472	-45%

The monthly average for the post delisting period starts in February 2005, instead of October 2004, because the period October 2004 to February 2005 represents a transitional period during which time patients previously taking Rofecoxib and other Cox II drugs switched to alternative treatments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-079

OUTCOME 2: Medicines and Medical Services

Topic: GROWTH IN OVERALL PBS SCRIPT VOLUMES

Hansard Page: CA 37

Senator Forshaw asked:

Can you give us the growth in overall PBS script volumes for the 2005 calendar year?

Answer:

For the twelve months ending 31 December 2005, Pharmaceutical Benefits Scheme (PBS) script volumes decreased by approximately 1.8 million on the corresponding period for the previous 12 months. This represented a 1.0% reduction.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-082

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE SAFETY NET

Hansard Page: CA 46/47

Senator McLucas asked:

The "cleanliness" goes to whether or not families are registering as families and people are being put into their correct family unit. How significant an issue is that in terms of actual numbers?

Answer:

Once the data becomes available from Medicare Australia, a response will be prepared and forwarded to the Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-126

OUTCOME 2: Medicines and Medical Services

Topic: REGISTRATION LEVELS - MEDICARE SAFETY NET

Hansard Page: CA 27

Senator McLucas asked:

Ms Halton - On 15 December Medicare Australia advise us that they could provide us with cleansed data that would comparable to the period required. At that point we took the decision that we would give you what we had. Senator McLucas - Are you confident that the table is correct? Ms Halton - I am confident that it is at the point at which they ran the run. That is exactly my point. We will take it on notice again this time, but we are going to try to get you cleansed data, actual month.

Answer:

Once the data becomes available from Medicare Australia, a response will be prepared and forwarded to the Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-077

OUTCOME 2: Medicines and Medical Services

Topic: PBS SCRIPT VOLUMES

Hansard Page: CA 37

Senator Forshaw asked:

I refer to the details that you have just read out about the movements in script volumes for particular drugs that have gone up and others that have gone down, it would be handy to have an analysis on paper of the overall picture with the break-up.

Answer:

The following table identifies the major increases and decreases in PBS prescription volumes by drug groups for 2004 and 2005.

PBS Prescription volume, Calendar year 2004 and 2005				
	2004	2005	Change	% change
Total PBS	170,253,375	168,490,329	-1,763,046	-1.0%
Drug groups with highest volume increase				
Lipid modifying agents (includes cholesterol lowering drugs)	15,592,264	16,739,465	1,147,201	7.4%
Drugs for acid related disorders (includes drugs to treat peptic ulcers)	12,811,783	13,393,687	581,904	4.5%
Antithrombotic agents (includes anti-clotting drugs)	4,881,893	5,320,669	438,776	9.0%
Drugs for treatment of bone diseases (includes drugs to treat osteoporosis)	2,641,102	3,010,792	369,690	14.0%
Drugs used in diabetes	5,151,410	5,358,288	206,878	4.0%
Drug groups with highest volume decrease				
Antiinflammatory and antirheumatic products (includes drugs to treat arthritis)	8,887,536	6,279,716	-2,607,820	-29.3%
Agents acting on the renin-angiotensin system (includes blood pressure lowering drugs)	20,171,543	19,634,902	-536,641	-2.7%
Sex hormones and modulators of the genital system (includes oral contraceptives and hormone replacement therapy drugs)	3,683,973	3,388,759	-295,214	-8.0%
Antiprotozoals (includes anti-infective and anti-malarial drugs)	560,863	287,588	-273,275	-48.7%
Analgesics (pain relievers)	11,160,598	10,951,639	-208,959	-1.9%

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-082

OUTCOME 2: Medicines and Medical Services

Topic: MEDICARE SAFETY NET

Hansard Page: CA 46/47

Senator McLucas:

The "cleanliness" goes to whether or not families are registering as families and people are being put into their correct family unit. How significant an issue is that in terms of actual numbers?

Answer:

Changes to Medicare Registration File involve both additions of new registrations and removal of families from the file.

During 2005, 417,882 new families were registered with Safety Net and 37,563 were deleted due to reasons including person leaving the country, death and divorce.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-126

OUTCOME 2: Medicines and Medical Services

Topic: REGISTRATION LEVELS - MEDICARE SAFETY NET

Hansard Page: CA 27

Senator McLucas asked:

Ms Halton - On 15 December Medicare Australia advised us that they could provide us with cleansed data that would be comparable to the period required. At that point we took the decision that we would give you what we had. Senator McLucas - Are you confident that the table is correct? Ms Halton - I am confident that it is at the point at which they ran the run. That is exactly my point. We will take it on notice again this time, but we are going to try to get you cleansed data, actual month data.

Answer:

Calendar Year 2005 #	Number of registered families	Net change during month (includes additions and deletions)
January	3,688,941	
February	3,731,986	43,045
March	3,773,096	41,110
April	3,812,065	38,969
May	3,849,966	37,901
June	3,884,300	34,334
July	3,916,610	32,310
August	3,951,185	34,575
September	3,982,739	31,554
October	4,010,847	28,108
November	4,037,436	26,589
December	4,059,818	22,382

Safety Net Family Registrations are provided at the end of each month (i.e. 31 Jan 2005) for the 2005 calendar year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-023

OUTCOME 3: Aged Care and Population Ageing

Topic: CARERS AND RESPITE CARE

Written Question on Notice

Senator Siewert asked:

a) What modelling is being done of the increasing demand for different types of respite and support services with changing demographics?

b) If modelling is being done – is this modelling taking into account increasing demands in regional centres with 'sea-change' and 'tree-change' retirees?

c) What planning is being done to ensure the development and provision of future services to meet increasing demand for respite and support services in regional centres?

d) Does the department have breakdowns of figures for individual regional centres?

e) If so can you provide the following detail for:
   i. Albany;
   ii. Bunbury;
   iii. Esperance; and
   iv. Geraldton in Western Australia

f) Following on from e) what number/proportion of the population in these areas are aged over 65? Aged over 85?

g) What number/proportion of the population of these are suffering from dementia?
   i. How many of these are in full time care?
   ii. How many are in family care?
   iii. How many of these family carers access respite services and how often?
   iv. What is the average number of days in care per year and what is the average length of respite provided?
   v. How many respite beds are available? How many of these respite beds are available in secure services? How many of these places are available for short-term respite (one or two days) versus longer term respite (one to two weeks)?
   vi. How far in advance does longer term respite need to be booked?
   vii. Are there emergency respite services available for when the primary carer suffers illness or injury? How many places/facilities?
   viii. What number/proportion are presenting challenging behaviour that requires secure care?

h) Does the department undertake long term planning to estimate the growth in demand for carer support services in regional centres?

i) Can you provide information for each of these regional centres?

a) What number/proportion of the population in 2025 do you estimate will be aged over 65? Aged over 85? In 2050?

b) What number/proportion of these are likely to be suffering from dementia?

i. How many are likely to be in full-time care?
ii. How many are likely to be in family care?
iii. How many of these family carers are likely to access respite services and how often?
iv. What is the likely number of days in care per year and the average length of respite provided?
v. How many beds are likely to be available? How many of these respite beds will be available in secure services? How many of these places will be available for short-term (one or two days)? Versus longer term respite (one to two weeks)?
vi. What emergency respite services will be available for when the primary carer suffers illness or injury? How many places / facilities?
vii. What number / proportion are likely to be presenting challenging behaviour that requires secure care? Will there be appropriate facilities and services available?

Answer:

a) Modelling for aged care places is based on Australian Bureau of Statistics (ABS) Population Projections. The Department uses the ABS Survey of Disability, Ageing and Carers (2003) to estimate the number of primary carers in each state and territory. The Department applies this population data to distribute funding at the state and territory level for carer support services under the National Respite for Carers Program (NRCP).

b) The ABS Population Projections take into account internal migration patterns.

c) See a).

d) The Department sources population estimates from the ABS 3222.0 Population Projections Series B, 2002 and these provide population estimates for regional centres or local government areas.

e)

		Population
2005	Albany (C)	32,498
	Bunbury (C)	31,512
	Esperance (S)	13,634
	Geraldton (C)	19,448

(C) City
(S) Shire

f)

		65+	85+	65+ % population	85+ % population
2005	Albany (C)	*5,073*	576	16%	2%
	Bunbury (C)	*4,159*	533	13%	<1%
	Esperance (S)	*1,509*	154	5%	0%
	Geraldton (C)	*2,894*	302	9%	1%

g) Information at a regional level on the number of people with dementia is not available. Projections at this level are generally viewed as unreliable. However, the following percentages, based on the work of Jorm and Henderson in 1998, can be more broadly applied to current population numbers and population projections to estimate current and future numbers of people with dementia.

Age Band	Prevalence % Rates by Age
60-64	0.7
65-69	1.42
70-74	2.82
75-79	5.6
80-84	11.11
85+	23.6

i. The number/proportion of the population who are suffering from dementia and are in full time care in these regional areas can not be accurately determined from current data collections.

ii. The number/proportion of the population who are suffering from dementia and are in family care in these regional areas can not be accurately determined from current data collections.

iii. The number of family carers who access respite services and how often in these regional areas can not be accurately determined from current data collections.

iv. This can not be accurately determined as data on the number of people in respite with dementia is not collected.

v.

Region	Allocated Respite Days
Albany (C)	4,559
Bunbury (C)	4,283
Esperance (S)	563
Geraldton (C)	1,841

Residential respite bed days are not allocated based on whether the beds are for the specific use of clients with dementia and challenging behaviours. The Accreditation Standards Outcomes 4.4 states that residents must be provided with a safe and comfortable living environment that is consistent with their needs.

Allocated beds can be used for either short or long term respite. The length of time of a residential respite stay is negotiated between the approved provider and the care recipient. The maximum amount of time that an individual recipient can receive residential respite is stipulated in the *Aged Care Act 1997* and is 63 days in a calendar year.

vi. The Department does not collect data on booking times for residential respite. This is determined by the individual aged care home.

vii. Although there is no specific allocation of emergency residential respite beds, the 11,246 allocated residential respite beds in these regions can be used in emergency situations depending on the aged care home. The Australian Government funds Commonwealth Carer Respite Centres (CCRC) to assist carers arrange respite in the case of illness or injury. CCRCs have the capacity to arrange respite for carers through existing services, including in-home and residential care. They also have a capacity to purchase or subsidise emergency respite care.

viii. The Department does not have data on the number of people with dementia that present with challenging behaviour requiring secure care in these regions.

h) The Department uses the Australian Bureau of Statistics Survey of Disability, Ageing and Carers (2003) to estimate the number of primary carers in each state and territory and to guide planning for carer support services funded through the National Respite for Carers Program (NRCP).

i) a)

	Population in 2022	
	65+	**85+**
Albany (C)	8,764	1,255
Bunbury (C)	7,019	900
Esperance (S)	2,780	338
Geraldton (C)	3,924	561

Source: Australian Bureau of Statistics Population Projections, Series B 2002. 3022.0.

Projections beyond 2022 are not produced by the ABS below State level as it is judged that such projections would be unreliable.

b) The prevalence percentages based on the work of Jorm and Henderson in 1998, detailed in question g), can be used to estimate that there will be approximately 550,000 Australians with dementia nationally in 2050.

i. There is no way of reliably predicting the likelihood of people suffering from dementia being in full-time care in 2025 and 2050.

ii. There is no way of reliably predicting the likelihood of people suffering from dementia
being in family care in 2025 and 2050.

iii. There is no way of reliably predicting the likelihood of carers of people suffering from
dementia accessing respite services in 2025 or 2050.

iv. There is no way of reliably predicting the likely number of days in care and the average length of respite provided in 2025 or 2050.

v. The number of beds likely to be available in 2025 and 2050 is not known.

vi. The availability of emergency respite services in 2025 and 2050 is not known.

vii. There is no way of reliably predicting the number/proportion that are likely to be presenting with challenging behaviour and require secure care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-034

OUTCOME 3: Aged Care and Population Ageing

Topic: CONDITIONAL ADJUSTMENT PAYMENT (CAP) REPORTING DEADLINE

Written Question on Notice

Senator McLucas asked:

(a) In an answer to a question on notice, 965 Approved Providers have lodged their Annual Notice indicating compliance with the CAP financial reporting. Is the Department able to ascertain how much money is spent on care, food, etc, at an individual facility level and at a provider level?
(b) Have any providers not complied with the CAP reporting deadlines so will lose CAP funding?
(c) If so, how many approved providers does this include and how many facilities will be affected?

Answer:

(a) No.

(b) Yes.

(c) In November 2005, 52 providers (corresponding to 78 services) did not comply with the Conditional Adjustment Payment (CAP) requirements and did not receive CAP for that month. However, as at February 2006, this number reduced to eight providers (corresponding to 10 services). This means that over 99% of approved providers were receiving CAP funding as at February 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-035

OUTCOME 3: Aged Care and Population Ageing

Topic: KIWI DALE AGED CARE BED LICENCES

Written Question on Notice

Senator McLucas asked:

a) Who is building the aged care facility in which Kiwi Dale will be using their 101 bed licences at 47 Rosanna Street, Carnegie, Victoria?
b) If it is another entity, will Kiwi Dale be renting the premises from that company?

Answer:

a) Australian Retirement Communities Pty Ltd.

b) Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-041

OUTCOME 3: Aged Care and Population Ageing

Topic: INDIGENOUS AGED CARE - TROICAS

Written Question on Notice

Senator McLucas asked:

(a) Could you provide details on how long Departmental staff were on site at the Mornington Island Aged Persons Hostel in days and hours, and total cost – including airfares?

(b) Could you also please advise whether the Department has had to fund consultants for other aged care facilities and Community Aged Care Package providers in Indigenous communities?

Answer:

(a) In 2005, Departmental staff were on site at Mornington Island's Aged Persons Hostels for 36 hours, with an estimated cost to the Department, including airfares, of $16,037.77.

(b) In 2005, the Department has funded consultancies for issues such as governance and management reviews.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-043

OUTCOME 3: Aged Care and Population Ageing

Topic: RESIDENTIAL AGED CARE BED VACANCIES

Written Question on Notice

Senator McLucas asked:

(a) Does the Government measure the number of aged care bed vacancies on a national level in Australia? If not, Why not?

(b) What is the residential aged care bed vacancy rate by state and territory and nationally.

Answer:

(a) Yes.

(b) Information on residential aged care vacancy rates at the end of the financial year 2004-05 is contained in the following table.

Jurisdiction	**Percentage Vacancy**
New South Wales	4.6
Victoria	5.9
Queensland	2.9
South Australia	2.6
Western Australia	4.2
Tasmania	4.7
Northern Territory	4.9
Australian Capital Territory	2.6
Australia	4.4

Vacancy is largely associated with client turnover, since there is often a delay between the departure of one resident and the arrival of a new resident.

The figures shown are for places that were not offline at the time. Information on offline places was provided in answer to the parliamentary question on notice [1450] asked in the Senate on 16 December 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-047

OUTCOME 3: Aged Care and Population Ageing

Topic: AGED CARE NURSE PRACTITIONERS

Written Question on Notice

Senator McLucas asked:

(a) The 2004-05 report on the Operation of the *Aged Care Act 1997* states that the Federal Government, with ACT health, is funding a pilot project to explore the role of Aged Care Nurse Practioners in the care of older people. The trial commenced in May 2004. Are there any preliminary results available and can they be provided?

Answer:

(a) A report on the ACT Aged Care Nurse Practitioner trial will be released at the end of April 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-049

OUTCOME 3: Aged Care and Population Ageing

Topic: ASSET TESTING OF NEW AGED CARE RESIDENTS

Written Question on Notice

Senator McLucas asked:

(a) How is the transfer of asset testing of new residents to Centrelink and DVA, legislated last year and starting from 1 July 2005, going?

(b) Has any person's entry to a residential aged care facility been delayed by the process?

(c) What happens if someone's circumstances change between the time Centrelink or DVA assess them and the time they enter care?

(d) How would Centrelink know there was a material change in circumstances?

Answer:

(a) Centrelink and the Department of Veterans' Affairs (DVA) have undertaken assets testing for residential aged care since 1 July 2005. To date, more than 20,000 assessments have been completed. Consultation with the aged care industry and other stakeholders is continuing, to clarify aspects of the new arrangements and to address any issues that arise.

(b) The Department understands that there have been some such instances. These have arisen largely because the resident, or a person acting on their behalf, has not known that priority is given to applications for assessments for people who enter care before submitting a request for an assets assessment, or where they are in hospital waiting for a place in a home, or have been offered a place in a home. To ensure this is understood, there have been efforts to ensure this is known to aged care providers, Aged Care Assessment Teams and other stakeholders.

(c) An assessment decision is valid from the date of the determination or the resident's date of entry to care, whichever is earlier, until the lapsing date advised in the notification which can vary depending on the nature of the assets held by the applicant. A person may enter care at any time while it remains valid. If a person's assets circumstances change during the validity period, they are able to request a re-assessment if they wish.

(d) Centrelink needs to be advised of any material change in circumstances by the applicant. An intending resident can do that by asking Centrelink or DVA for a fresh assets assessment at any time prior to entry into residential aged care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-050

OUTCOME 3: Aged Care and Population Ageing

Topic: WEBSTER PACKS

Written Question on Notice

Senator McLucas asked:

If a packing system (such as a Webster pack) is the chosen administration system for medication in a particular aged care facility, is the resident required to pay the pharmacist or the aged provider for this service?

Answer:

Item 2.4 of the Specified Care and Services Schedule in the Quality of Care Principles 1997 states that approved providers must have in place a system for ordering, recording, safe storage and administering of medications. If a packaging system is the chosen medication administration system, then the approved provider must pay for this system and must not charge the resident, or arrange for the pharmacist to charge the resident. If a resident chooses to have a different medication system, then the approved provider is not obliged to provide this at no additional cost.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-051

OUTCOME 3: Aged Care and Population Ageing

Topic: RESIDENT CLASSIFICATION SCALE REVIEWS

Written Question on Notice

Senator McLucas asked:

(b) Please provide RCS review figures for the six months ending December 2005.

(c) What is the proportion of the residents of aged care facilities values of downgrades/upgrades?

Answer:

(a) For the six months ending December 2005 there were 8,572 Resident Classification Scale reviews conducted.

(b) Of the 8,572 reviews carried out over this period, 38% were downgraded and 4% were upgraded.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2005

Question: E06-052

OUTCOME 3: Aged Care and Population Ageing

Topic: ACFI TRIAL

Senator McLucas asked:

(a) When will the results of the ACFI trial be available?
(b) If the report is complete can it be provided?

Answer:

(a) and (b)
The results of the Aged Care Funding Instrument (ACFI) trial are expected to be available to Government for consideration in April 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-053

OUTCOME 3: Aged Care and Population Ageing

Topic: COMMONWEALTH CARELINK

Written Question on Notice

Senator McLucas asked:

(a) There was an advertisement for Commonwealth Carelink in the Weekend Australian 21-22 January 2006. How much is spent on advertising for Commonwealth Carelink?

(b) Who pays for the advertisements, the Department or the provider of this service?

Answer:

(a) National advertising for Commonwealth Carelink has been undertaken on a two monthly basis. Year to date expenditure in 2005-06 for Commonwealth Carelink is approximately $343,200. The cost per bi-monthly schedule is around $77,000.

(b) The Department pays for national advertising of the Commonwealth Carelink Program and the Centres are funded to complement this effort with regionally based advertising and promotion.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-055

OUTCOME 3: Aged Care and Population Ageing

Topic: HOME AND COMMUNITY CARE (HACC) FUNDING

Written Question on Notice

Senator McLucas asked:

(a) Can you provide data that shows Commonwealth-State funding under the HACC program over the past five years and projections for the next three years?
(b) Could you also provide data showing average HACC expenditure per client over the past five years?
(c) Do you have estimates of estimates of unmet need with respect to HACC services?

Answers:

(a) Commonwealth and State/Territory funding under the HACC Program for the current and previous five years and projections for the next two years are presented below. Figures for 2008-09 are not publicly available.

COMMONWEALTH-STATE HACC PROGRAM FUNDING ($m)

	2000-01	**2001-02**	**2002-03**	**2003-04**	**2004-05**	**2005-06**	**2006-07**	**2007-08**
C'wealth	567.127	615.582	674.086	732.388	791.858	857.835	929.310	1005.755
States/Ter	364.818	396.792	434.129	471.312	509.224	551.055	*596.309	*644.634
Total:	931.945	1012.374	1108.215	1203.700	1301.082	1408.890	*1525.69	*1650.389

- *Dependent on matching by States/Territories.

(b) The Department is able to provide average HACC expenditure per client for the last four years only. This is because the HACC Minimum Data Set (MDS) only began to be collected from January 2001. Data for 2005-2006 will become available in 2006-2007.

AVERAGE HACC EXPENDITURE PER CLIENT

	2001-2002	**2002-2003**	**2003-2004**	**2004-2005**	**2005-2006**
Clients	583,156	661,062	707,207	744,197	N/A
Average cost: client per year	$1,736.03	$1,676.42	$1,702.05	$1,748.30	N/A

(c) Estimates of unmet need are not undertaken by the Department. Estimates of relative need between areas and service types is undertaken by State and Territory Governments as part of their HACC planning process which is used to inform priority for growth and allocation to regions by service types.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2005

Question: E06-086

OUTCOME 3: Aged Care and Population Ageing

Topic: JACKSON WELLS MORRIS

Hansard Page: CA 71-72

Senator Forshaw asked:

Does the Department have any contract with Jackson Wells Morris to undertake issues management on aged care?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-110

OUTCOME 3: Aged Care and Population Ageing

Topic: APPROVED PROVIDERS

Hansard Page: CA 70

Senator McLucas asked:

Was the Department aware that the prospective owner of Barton Vale – that is the bed owner - was the previous owner of St Davids?

Answer:

The Approved Provider of Barton Vale Nursing Home is Tolega Pty. Ltd. The Department was aware at the time Tolega applied for approval as the Approved Provider of Barton Vale Nursing Home, that one of Tolega's Directors was also a Director of Karoona Pty. Ltd., the former owner of St. David's Nursing Home.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-112

OUTCOME 3: Aged Care and Population Ageing

Topic: CLOSURE OF RESIDENTIAL AGED CARE FACILITIES

Hansard Page: CA 71

Senator McLucas asked:

Could I have on notice the number of residential aged care facilities which have closed in the last two years?

Answer:

Fifty two residential aged care services closed over the two calendar years of 2004 and 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-108

OUTCOME 3: Aged Care and Population Ageing

Topic: CERTIFICATION FIRE STANDARDS

Hansard Page: CA 58

Senator McLucas asked:

Do you know whether the residents of the 8 facilities have been advised of the status of their facility?

Answer:

The Department of Health and Ageing has ensured that the relevant approved provider has informed all residents of the eight residential aged care homes that have not met the state, territory or local government fire safety regulations, of the situation at their respective homes and the plans the homes have to meet these requirements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-109

OUTCOME 3: Aged Care and Population Ageing

Topic: WEBSITE – ST DAVIDS SANCTION REPORT 2001

Hansard Page: CA 70

Senator McLucas asked:

What happened as a result of the sanction?

Answer:

Sanctions were imposed on Karoona Pty Ltd, the approved provider of St David's Nursing Home in St Peters, South Australia on 17 May 2001. The Department of Health and Ageing made the decision to lift one of the sanctions on 1 August 2001 and the remaining sanction expired on 17 November 2001.

Karoona Pty Ltd made the decision to close the home in April 2003 and all residents were transferred to a new residential aged care service. Karoona Pty Ltd ceased to be an approved provider under the *Aged Care Act 1997* in November 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-044

OUTCOME 3: Aged Care and Population Ageing

Topic: FUNDING

Written Question on Notice

Senator McLucasasked:

(a) Could you give a detailed breakdown of the budget for the Aged Care Standards and Accreditation Agency, ie a table showing in some detail just what the Agency spends its funds on.

(b) Is there currently any backlog in terms of inspections, accreditations or approvals?

Answer:

(a)

Agency expenses for 2004/05 were:	$18,681,562
Employee expenses:	$13,483,864
Travel:	$ 1,270,031
Occupancy:	$ 1,568,981
Depreciation and ammortisation:	$ 276,618
Telecommunications:	$ 254,931
Training and recruitment:	$ 341,326
Other	$ 1,485,811
Total	$18,681,562

(b) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-038

OUTCOME 3: Aged Care and Population Ageing

Topic: ACCREDITATION REVOKED

Written Question on Notice

Senator McLucas asked:

(a) Have there been any facilities in Australia since the introduction of the Aged Care Act 1997 that have had their accreditation revoked and if so, how many?

(b) Can you inform me as to whether facilities were closed down by the Department, or if the facility closed down voluntarily because they lost their accreditation?

(c) Why are there no reports available on either the Department's or the Accreditation Agency's website on aged care facilities that lose their accreditation and close down? Don't the public have a right to know who the providers were when choosing care for themselves or their family members?

(d) How does the Accreditation Agency assess Outcome 2.4 – Clinical care?

Answer:

(a) Since accreditation commenced in September 1999, 11 homes have had their accreditation revoked, but nine were subsequently re-accredited after reconsideration.

(b) The Department of Health and Ageing has not closed any residential aged care homes as a result of the home losing its accreditation. Of the two homes that were not re-accredited, one approved provider made the decision voluntarily to close its home and the other is currently awaiting a decision on its application for reconsideration.

(c) The Agency publishes on its website reports relating to decisions to revoke or refuse accreditation. Residents and their representatives are informed by the Department of decisions to revoke or to refuse accreditation, in addition to being informed of any subsequent compliance action taken by the Department.

(d) The Agency publication, *Audit Handbook for Assessors*, describes the processes to be followed in audits. The Agency publication, *Results and Processes in Relation to the Expected Outcomes of the Accreditation Standards*, sets out relevant considerations for assessment against each of the expected outcomes.

Both these publications are available through the Agency website at www.accreditation.org.au

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Budget Estimates 2005-2006, 16 February 2006

Question: E06-107

OUTCOME 3: Aged Care and Population Ageing

Topic: FIRE SAFETY CERTIFICATION

Hansard page: CA55

Senator McLucas asked:

How many people decided to leave the industry and sell up through the accreditation and certification process?

Answer:

The Department does not maintain specific statistics on the reason for individual closures or restructuring within the industry, however, fifty two residential aged care services closed over the two calendar years of 2004 and 2005.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-111

OUTCOME 3: Aged Care and Population Ageing

Topic: BARTON VALE – MEDIA COMMENT FROM NURSE ADVISER

Hansard Page: CA 71

Senator McLucas asked:

What action did the Department take as a result of the comment made by the Nurse Adviser?

Answer:

The comments were attributed to Mr Neil Baron, who was not the adviser at Barton Vale Nursing Home. The Aged Care Standards and Accreditation Agency wrote to Mr Baron on 9 January 2006 seeking a list of homes to which Mr Baron was referring. Mr Baron replied that he had been misquoted and taken out of context and did not provide the information requested.

Australian Government

Department of Health and Ageing

Mr Elton Humphery
Committee Secretary
Community Affairs Committee
Department of the Senate
Parliament House
CANBERRA ACT 2600

Dear Mr Humphrey

Provision of December 2005 Stocktake Data
Outcome 3 – Enhanced Quality of Care for Older Australian

At the Budget Estimates 2004-2005 Hearings of the Senate Community Affairs Legislation Committee the Department undertook to forward to the Committee the figures for future stocktakes of aged care places following their completion.

The December 2005 stocktake figures are attached.

Yours sincerely

Stephen Dellar
Assistant Secretary
Residential Program management Branch
March 2006

Total Allocated Places by State / Territory

as at 31 December 2005

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	32,296	33,300	**65,596**	13,085	173	**78,854**
VIC	22,363	26,382	**48,745**	9,982	150	**58,877**
QLD	15,393	17,705	**33,098**	6,542	106	**39,746**
SA	8,367	8,592	**16,959**	3,472	90	**20,521**
WA	7,357	8,770	**16,127**	3,374	50	**19,551**
TAS	2,499	2,333	**4,832**	1,078	20	**5,930**
NT	328	236	**564**	695	-	**1,259**
ACT	918	1,308	**2,226**	541	10	**2,777**
Australia	89,521	98,626	**188,147**	38,769	599	**227,515**

Total Allocated Ratio by State / Territory

as at 31 December 2005

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	48.9	50.4	**99.3**	19.8	0.3	**119.3**
VIC	46.0	54.3	**100.3**	20.5	0.3	**121.1**
QLD	46.0	53.0	**99.0**	19.6	0.3	**118.9**
SA	48.8	50.1	**98.9**	20.2	0.5	**119.7**
WA	44.9	53.5	**98.3**	20.6	0.3	**119.2**
TAS	50.2	46.9	**97.1**	21.7	0.4	**119.2**
NT	66.6	47.9	**114.6**	141.2	-	**255.8**
ACT	42.5	60.6	**103.2**	25.1	0.5	**128.7**
Australia	47.3	52.1	**99.4**	20.5	0.3	**120.2**

Note: Tables include flexible care places: Transition Care (TC), Extended Aged Care at Home (EACH), EACH Dementia, Multipurpose Services (MPS), permanently allocated Innovative Care (IC) places and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI). EACH and EACH Dementia places are attributed as community care while MPS, IC and ATSI flexible care places are attributed as high care, low care and community care packages.

		31 December 2005 - Total allocated places						31 December 2005 - Total allocated ratio					
State / Territory	Aged Care Planning Region	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL
NSW	Central Coast	1,660	2,059	3,719	891	-	**4,610**	40.2	49.9	**90.1**	21.6	-	**111.7**
	Central West	789	941	1,730	345	-	**2,075**	44.5	53.0	**97.5**	19.4	-	**116.9**
	Far North Coast	1,498	1,932	3,430	725	-	**4,155**	41.6	53.7	**95.4**	20.2	-	**115.5**
	Hunter	2,752	3,150	5,902	1,178	-	**7,080**	44.5	51.0	**95.5**	19.1	-	**114.6**
	Illawarra	1,712	2,366	4,078	955	-	**5,033**	40.7	56.2	**96.9**	22.7	-	**119.6**
	Inner West	3,259	1,677	4,936	789	-	**5,725**	79.4	40.9	**120.3**	19.2	-	**139.5**
	Mid North Coast	1,682	2,259	3,941	851	-	**4,792**	41.7	56.0	**97.8**	21.1	-	**118.9**
	Nepean	1,251	957	2,208	419	-	**2,627**	61.3	46.9	**108.2**	20.5	-	**128.7**
	New England	829	992	1,821	366	-	**2,187**	44.9	53.8	**98.7**	19.8	-	**118.6**
	Northern Sydney	4,656	4,300	8,956	1,418	-	**10,374**	56.2	51.9	**108.0**	17.1	-	**125.1**
	Orana Far West	596	919	1,515	385	-	**1,900**	39.4	60.8	**100.3**	25.5	-	**125.7**
	Riverina/Murray	1,210	1,510	2,720	549	-	**3,269**	43.6	54.4	**98.0**	19.8	-	**117.8**
	South East Sydney	3,886	3,691	7,577	1,661	-	**9,238**	47.0	44.7	**91.7**	20.1	-	**111.8**
	South West Sydney	2,814	2,968	5,782	1,172	-	**6,954**	47.2	49.7	**96.9**	19.6	-	**116.5**
	Southern Highlands	844	1,317	2,161	421	-	**2,582**	38.2	59.7	**97.9**	19.1	-	**117.0**
	Western Sydney	2,858	2,262	5,120	960	-	**6,080**	55.6	44.0	**99.5**	18.7	-	**118.2**
NEW SOUTH WALES TOTAL		32,296	33,300	**65,596**	13,085	173	**78,854**	48.9	50.4	**99.3**	19.8	0.3	**119.3**
VIC	Barwon-South Western	1,853	2,182	4,035	835	-	**4,870**	45.6	53.7	**99.3**	20.6	-	**119.9**
	Eastern Metro	4,321	5,370	9,691	1,930	-	**11,621**	44.4	55.1	**99.5**	19.8	-	**119.3**
	Gippsland	1,221	1,524	2,745	598	-	**3,343**	43.4	54.1	**97.5**	21.2	-	**118.8**

	Grampians	1,026	1,253	2,279	487	-	**2,766**	44.4	54.2	**98.6**	21.1	-	**119.7**
	Hume	1,202	1,537	2,739	580	-	**3,319**	44.9	57.4	**102.3**	21.7	-	**123.9**
	Loddon-Mallee	1,404	1,811	3,215	667	-	**3,882**	42.4	54.7	**97.1**	20.1	-	**117.2**
	Northern Metro	3,476	3,600	7,076	1,508	-	**8,584**	50.4	52.2	**102.7**	21.9	-	**124.5**
	Southern Metro	5,550	6,283	11,833	2,304	-	**14,137**	47.1	53.3	**100.4**	19.6	-	**120.0**
	Western Metro	2,310	2,822	5,132	1,073	-	**6,205**	46.1	56.3	**102.4**	21.4	-	**123.8**
VICTORIA TOTAL		22,363	26,382	**48,745**	9,982	150	**58,877**	46.0	54.3	**100.3**	20.5	0.3	**121.1**
QLD	Brisbane North	2,180	2,100	4,280	720	-	**5,000**	53.7	51.7	**105.4**	17.7	-	**123.2**
	Brisbane South	2,775	2,831	5,606	974	-	**6,580**	50.6	51.6	**102.2**	17.8	-	**120.0**
	Cabool	1,179	1,399	2,578	468	-	**3,046**	46.3	54.9	**101.2**	18.4	-	**119.6**
	Central West	63	49	112	61	-	**173**	63.7	49.5	**113.2**	61.7	-	**174.9**
	Darling Downs	1,029	1,159	2,188	407	-	**2,595**	46.4	52.2	**98.6**	18.3	-	**116.9**
	Far North	660	838	1,498	420	-	**1,918**	40.7	51.7	**92.4**	25.9	-	**118.3**
	Fitzroy	663	794	1,457	317	-	**1,774**	45.8	54.9	**100.7**	21.9	-	**122.6**
	Logan River Valley	632	898	1,530	297	-	**1,827**	43.1	61.3	**104.4**	20.3	-	**124.6**
	Mackay	364	437	801	181	-	**982**	41.9	50.3	**92.1**	20.8	-	**113.0**
	North West	59	78	137	99	-	**236**	39.5	52.3	**91.8**	66.4	-	**158.2**
	Northern	784	787	1,571	303	-	**1,874**	51.0	51.2	**102.3**	19.7	-	**122.0**
	South Coast	1,888	2,245	4,133	819	-	**4,952**	43.1	51.2	**94.3**	18.7	-	**113.0**
	South West	74	149	223	97	-	**320**	36.3	73.1	**109.4**	47.6	-	**156.9**
	Sunshine Coast	1,472	1,931	3,403	671	-	**4,074**	40.7	53.4	**94.2**	18.6	-	**112.7**
	West Moreton	491	738	1,229	223	-	**1,452**	38.9	58.5	**97.4**	17.7	-	**115.1**
	Wide Bay	1,080	1,272	2,352	485	-	**2,837**	43.8	51.5	**95.3**	19.6	-	**114.9**
							39,746						

QUEENSLAND TOTAL		15,393	17,705	**33,098**	6,542	106		46.0	53.0	**99.0**	19.6	0.3	**118.9**
SA	Eyre Peninsula	125	182	307	83	-	**390**	35.6	51.9	**87.5**	23.7	-	**111.2**
	Hills, Mallee & Southern	567	613	1,180	295	-	**1,475**	44.9	48.6	**93.5**	23.4	-	**116.9**
	Metropolitan East	2,286	1,882	4,168	563	-	**4,731**	65.3	53.8	**119.1**	16.1	-	**135.2**
	Metropolitan North	1,458	1,185	2,643	412	-	**3,055**	59.9	48.7	**108.5**	16.9	-	**125.4**
	Metropolitan South	1,733	1,829	3,562	802	-	**4,364**	44.8	47.3	**92.0**	20.7	-	**112.7**
	Metropolitan West	1,254	1,286	2,540	585	-	**3,125**	43.0	44.1	**87.2**	20.1	-	**107.2**
	Mid North	69	227	296	87	-	**383**	19.6	64.5	**84.1**	24.7	-	**108.9**
	Riverland	146	238	384	118	-	**502**	32.0	52.1	**84.1**	25.8	-	**109.9**
	South East	189	358	547	138	-	**685**	30.5	57.7	**88.2**	22.3	-	**110.5**
	Whyalla, Flinders & Far North	142	209	351	153	-	**504**	37.2	54.7	**91.9**	40.1	-	**132.0**
	Yorke, Lower North & Barossa	398	583	981	236	-	**1,217**	39.5	57.9	**97.5**	23.4	-	**120.9**
SOUTH AUSTRALIA TOTAL		8,367	8,592	**16,959**	3,472	90	**20,521**	48.8	50.1	**98.9**	20.2	0.5	**119.7**
WA	Goldfields	148	134	282	69	-	**351**	60.3	54.6	**115.0**	28.1	-	**143.1**
	Great Southern	288	388	676	162	-	**838**	40.6	54.7	**95.3**	22.8	-	**118.1**
	Kimberley	68	92	160	60	-	**220**	63.3	85.6	**148.8**	55.8	-	**204.7**
	Metropolitan East	1,196	1,385	2,581	510	-	**3,091**	48.1	55.7	**103.7**	20.5	-	**124.2**
	Metropolitan North	1,737	2,349	4,086	782	-	**4,868**	41.1	55.5	**96.6**	18.5	-	**115.0**
	Metropolitan South East	1,626	1,477	3,103	607	-	**3,710**	59.3	53.9	**113.2**	22.1	-	**135.3**
	Metropolitan South West	1,504	1,792	3,296	635	-	**3,931**	40.7	48.4	**89.1**	17.2	-	**106.2**
	Mid West	150	221	371	121	-	**492**	32.7	48.1	**80.8**	26.3	-	**107.1**
	Pilbara	30	53	83	50	-	**133**	48.8	86.2	**135.0**	81.3	-	**216.3**
	South West	472	704	1,176	260	-	**1,436**	40.2	59.9	**100.1**	22.1	-	**122.2**
	Wheatbelt	138	175	313	118	-	**431**	28.9	36.6	**65.5**	24.7	-	**90.2**
WESTERN AUSTRALIA TOTAL						50	**19,551**						

		7,357	8,770	**16,127**	3,374			44.9	53.5	**98.3**	20.6	0.3	**119.2**
TAS	North Western	500	511	1,011	227	-	**1,238**	43.8	44.8	**88.7**	19.9	-	**108.6**
	Northern	814	643	1,457	336	-	**1,793**	56.8	44.9	**101.7**	23.5	-	**125.1**
	Southern	1,185	1,179	2,364	515	-	**2,879**	49.3	49.1	**98.4**	21.4	-	**119.8**
TASMANIA TOTAL		2,499	2,333	**4,832**	1,078	20	**5,930**	50.2	46.9	**97.1**	22.4	0.4	**119.2**
NT	Alice Springs	110	56	166	196	-	**362**	114.7	58.4	**173.1**	204.4	-	**377.5**
	Barkly	17	2	19	42	-	**61**	146.6	17.2	**163.8**	362.1	-	**525.9**
	Darwin	169	131	300	307	-	**607**	51.1	39.6	**90.7**	92.8	-	**183.4**
	East Arnhem	5	6	11	72	-	**83**	36.5	43.8	**80.3**	525.5	-	**605.8**
	Katherine	27	41	68	78	-	**146**	67.3	102.2	**169.6**	194.5	-	**364.1**
NORTHERN TERRITORY TOTAL		328	236	**564**	695	-	**1,259**	66.6	47.9	**114.6**	141.2	-	**255.8**
ACT	Australian Capital Territory	918	1,308	2,226	541	-	**2,767**	42.5	60.6	**103.2**	25.1	-	**128.2**
AUSTRALIAN CAPITAL TERRITORY TOTAL		918	1,308	**2,226**	541	10	**2,777**	42.5	60.6	**103.2**	25.1	0.5	**128.7**
AUSTRALIAN TOTAL		89,521	98,626	**188,147**	38,769	599	**227,515**	47.3	52.1	**99.4**	20.5	0.3	**120.2**

Total Allocated Places by Service Type as at 31 December 2005

Mainstream allocated places (residential and community care places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	31,785	33,036	**64,821**	11,893		**76,714**
VIC	22,168	26,248	**48,416**	9,015		**57,431**
QLD	15,196	17,560	**32,756**	5,890		**38,646**
SA	8,214	8,426	**16,640**	3,125		**19,765**
WA	7,080	8,432	**15,512**	2,962		**18,474**
TAS	2,445	2,300	**4,745**	935		**5,680**
NT	283	182	**465**	559		**1,024**
ACT	918	1,308	**2,226**	456		**2,682**
Australia	88,089	97,492	**185,581**	34,835		**220,416**

Multipurpose allocated places

(flexible places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	505	249	**754**	74		**828**
VIC	180	124	**304**	14		**318**
QLD	156	113	**269**	92		**361**
SA	95	124	**219**	14		**233**
WA	250	304	**554**	117		**671**
TAS	54	33	**87**	7		**94**
NT	-	-	**-**	-		**-**
ACT	-	-	**-**	-		**-**
Australia	1,240	947	**2,187**	318		**2,505**

National Aboriginal and Torres Strait Islander Aged Care Strategy allocated places (not allocated under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	6	15	**21**	34		**55**
VIC	15	10	**25**	69		**94**
QLD	41	32	**73**	6		**79**
SA	58	42	**100**	45		**145**
WA	6	8	**14**	2		**16**
TAS	-	-	**-**	41		**41**
NT	45	54	**99**	66		**165**
ACT	-	-	**-**	-		**-**
Australia	171	161	**332**	263		**595**

Extended Aged Care at Home (EACH) allocated places

(flexible places under the Aged Care Act 1997)

*EACH places are attributed as Community Care from 30 June 2004.

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW			**-**	859		859
VIC			**-**	718		718
QLD			**-**	439		439
SA			**-**	230		230
WA			**-**	235		235
TAS			**-**	75		75
NT			**-**	60		60
ACT			**-**	70		70
Australia			**-**	**2,686**		2,686

EACH Dementia allocated places
(flexible places under the Aged Care Act 1997)
*EACH Dementia places are attributed as Community Care from 31 December 2005.

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	-	-	**-**	225		**225**
VIC	-	-	**-**	166		**166**
QLD	-	-	**-**	115		**115**
SA	-	-	**-**	58		**58**
WA	-	-	**-**	58		**58**
TAS	-	-	**-**	20		**20**
NT	-	-	**-**	10		**10**
ACT	-	-	**-**	15		**15**
Australia	0	0	**-**	667		**667**

Innovative Care allocated places
(flexible places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW			**-**			**-**
VIC			**-**			**-**
QLD			**-**			**-**
SA			**-**			**-**
WA	21	26	**47**	-	-	**47**
TAS			**-**			**-**
NT			**-**			**-**
ACT			**-**			**-**
Australia	21	26	**47**	-	-	**47**

Transition Care (TC) allocated places
(flexible places under the Aged Care Act 1997)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW			**-**		173	**173**
VIC			**-**		150	**150**
QLD			**-**		106	**106**
SA			**-**		90	**90**
WA			**-**		50	**50**
TAS			**-**		20	**20**
NT			**-**		-	**-**
ACT			**-**		10	**10**
Australia			**-**	**-**	**599**	**599**

Total Operational Places by State / Territory

as at 31 December 2005

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	29,838	26,358	**56,196**	11,251	-	**67,447**
VIC	19,333	22,530	**41,863**	8,454	-	**50,317**
QLD	13,284	15,484	**28,768**	6,055	-	**34,823**
SA	7,908	8,018	**15,926**	3,000	90	**19,016**
WA	6,447	7,714	**14,161**	2,792	-	**16,953**
TAS	2,273	2,117	**4,390**	988	-	**5,378**
NT	306	228	**534**	665	-	**1,199**
ACT	663	931	**1,594**	466	10	**2,070**
Australia	**80,052**	**83,380**	**163,432**	**33,671**	**100**	**197,203**

Total Operational Ratio by State / Territory

as at 31 December 2005

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES
NSW	45.2	39.9	**85.1**	17.0	-	**102.1**
VIC	39.8	46.4	**86.1**	17.4	-	**103.5**
QLD	39.7	46.3	**86.1**	18.1	-	**104.2**
SA	46.1	46.8	**92.9**	17.5	0.5	**110.9**
WA	39.3	47.0	**86.4**	17.0	-	**103.4**
TAS	45.7	42.5	**88.2**	19.9	-	**108.1**
NT	62.2	46.3	**108.5**	135.1	-	**243.6**
ACT	30.7	43.1	**73.9**	21.6	0.5	**95.9**
Australia	42.3	44.1	**86.3**	17.8	0.1	**104.2**

Note: Tables include flexible care places: Transition Care (TC), Extended Aged Care at Home (EACH), EACH Dementia, Multipurpose Services (MPS), permanently allocated Innovative Care (IC) places and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI). EACH and EACH Dementia places are attributed as community care while MPS, IC and ATSI flexible care places are attributed as high care, low care and community care packages.

State / Territory	Aged Care Planning Region	31 December 2005 - Total operational places						31 December 2005 - Total operational ratio					
		HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES	HIGH	LOW	RESI	Community Care	Transition Care	TOTAL PLACES
NSW	Central Coast	1,543	1,493	3,036	741	-	**3,777**	37.4	36.2	**73.6**	18.0	-	**91.5**
	Central West	779	898	1,677	291	-	**1,968**	43.9	50.6	**94.5**	16.4	-	**110.9**
	Far North Coast	1,278	1,507	2,785	620	-	**3,405**	35.5	41.9	**77.4**	17.2	-	**94.7**
	Hunter	2,521	2,616	5,137	966	-	**6,103**	40.8	42.3	**83.1**	15.6	-	**98.8**
	Illawarra	1,432	1,528	2,960	765	-	**3,725**	34.0	36.3	**70.3**	18.2	-	**88.5**
	Inner West	3,121	1,469	4,590	754	-	**5,344**	76.0	35.8	**111.8**	18.4	-	**130.2**
	Mid North Coast	1,330	1,733	3,063	711	-	**3,774**	33.0	43.0	**76.0**	17.6	-	**93.6**
	Nepean	1,229	712	1,941	359	-	**2,300**	60.2	34.9	**95.1**	17.6	-	**112.7**
	New England	744	866	1,610	336	-	**1,946**	40.3	47.0	**87.3**	18.2	-	**105.5**
	Northern Sydney	4,516	3,971	8,487	1,174	-	**9,661**	54.5	47.9	**102.4**	14.2	-	**116.5**
	Orana Far West	567	834	1,401	359	-	**1,760**	37.5	55.2	**92.7**	23.8	-	**116.5**
	Riverina/Murray	990	1,274	2,264	479	-	**2,743**	35.7	45.9	**81.6**	17.3	-	**98.8**
	South East Sydney	3,533	2,459	5,992	1,521	-	**7,513**	42.8	29.8	**72.5**	18.4	-	**90.9**
	South West Sydney	2,749	2,180	4,929	1,027	-	**5,956**	46.1	36.5	**82.6**	17.2	-	**99.8**
	Southern Highlands	704	1,062	1,766	346	-	**2,112**	31.9	48.1	**80.0**	15.7	-	**95.7**
	Western Sydney	2,802	1,756	4,558	802	-	**5,360**	54.5	34.1	**88.6**	15.6	-	**104.2**
NEW SOUTH WALES TOTAL		29,838	26,358	**56,196**	11,251	-	**67,447**	45.2	39.9	**85.1**	17.0	-	102.1
VIC	Barwon-South Western	1,663	1,897	3,560	760	-	**4,320**	40.9	46.7	**87.6**	18.7	-	**106.3**
	Eastern Metro	3,710	4,717	8,427	1,500	-	**9,927**	38.1	48.4	**86.5**	15.4	-	**101.9**
	Gippsland	989	1,329	2,318	488	-	**2,806**	35.1	47.2	**82.4**	17.3	-	**99.7**

	Grampians	921	1,107	2,028	447	-	**2,475**	39.9	47.9	**87.8**	19.3	-	**107.1**
	Hume	1,074	1,281	2,355	515	-	**2,870**	40.1	47.8	**87.9**	19.2	-	**107.2**
	Loddon-Mallee	1,313	1,570	2,883	587	-	**3,470**	39.7	47.4	**87.1**	17.7	-	**104.8**
	Northern Metro	2,855	2,927	5,782	1,283	-	**7,065**	41.4	42.5	**83.9**	18.6	-	**102.5**
	Southern Metro	4,892	5,368	10,260	1,923	-	**12,183**	41.5	45.6	**87.1**	16.3	-	**103.4**
	Western Metro	1,916	2,334	4,250	951	-	**5,201**	38.2	46.6	**84.8**	19.0	-	**103.8**
VICTORIA TOTAL		19,333	22,530	**41,863**	8,454	-	**50,317**	39.8	46.4	**86.1**	17.4	-	103.5
QLD	Brisbane North	2,013	1,978	3,991	680	-	**4,671**	49.6	48.7	**98.3**	16.8	-	**115.1**
	Brisbane South	2,479	2,562	5,041	899	-	**5,940**	45.2	46.7	**91.9**	16.4	-	**108.3**
	Cabool	986	1,170	2,156	383	-	**2,539**	38.7	45.9	**84.6**	15.0	-	**99.7**
	Central West	63	49	112	61	-	**173**	63.7	49.5	**113.2**	61.7	-	**174.9**
	Darling Downs	967	1,109	2,076	407	-	**2,483**	43.6	50.0	**93.6**	18.3	-	**111.9**
	Far North	613	783	1,396	413	-	**1,809**	37.8	48.3	**86.1**	25.5	-	**111.5**
	Fitzroy	565	746	1,311	289	-	**1,600**	39.0	51.6	**90.6**	20.0	-	**110.6**
	Logan River Valley	380	582	962	287	-	**1,249**	25.9	39.7	**65.6**	19.6	-	**85.2**
	Mackay	350	393	743	171	-	**914**	40.3	45.2	**85.5**	19.7	-	**105.1**
	North West	46	78	124	94	-	**218**	30.8	52.3	**83.1**	63.0	-	**146.1**
	Northern	727	779	1,506	303	-	**1,809**	47.3	50.7	**98.1**	19.7	-	**117.8**
	South Coast	1,430	1,838	3,268	672	-	**3,940**	32.6	41.9	**74.5**	15.3	-	**89.9**
	South West	72	149	221	97	-	**318**	35.3	73.1	**108.4**	47.6	-	**156.0**
	Sunshine Coast	1,219	1,510	2,729	651	-	**3,380**	33.7	41.8	**75.5**	18.0	-	**93.5**
	West Moreton	481	675	1,156	198	-	**1,354**	38.1	53.5	**91.6**	15.7	-	**107.3**
	Wide Bay	893	1,083	1,976	450	-	**2,426**	36.2	43.9	**80.1**	18.2	-	**98.3**
QUEENSLAND TOTAL				**28,768**									

		13,284	15,484		6,055	-	**34,823**	39.7	46.3	**86.1**	18.1	-	104.2
SA	Eyre Peninsula	106	182	288	83	-	**371**	30.2	51.9	**82.1**	23.7	-	**105.8**
	Hills, Mallee & Southern	512	553	1,065	239	-	**1,304**	40.6	43.8	**84.4**	18.9	-	**103.4**
	Metropolitan East	2,245	1,876	4,121	478	-	**4,599**	64.1	53.6	**117.7**	13.7	-	**131.4**
	Metropolitan North	1,261	1,014	2,275	382	-	**2,657**	51.8	41.6	**93.4**	15.7	-	**109.1**
	Metropolitan South	1,608	1,638	3,246	686	-	**3,932**	41.5	42.3	**83.9**	17.7	-	**101.6**
	Metropolitan West	1,244	1,192	2,436	528	-	**2,964**	42.7	40.9	**83.6**	18.1	-	**101.7**
	Mid North	65	216	281	67	-	**348**	18.5	61.4	**79.9**	19.0	-	**98.9**
	Riverland	146	238	384	83	-	**467**	32.0	52.1	**84.1**	18.2	-	**102.2**
	South East	187	335	522	104	-	**626**	30.2	54.0	**84.2**	16.8	-	**101.0**
	Whyalla, Flinders & Far North	137	191	328	128	-	**456**	35.9	50.0	**85.9**	33.5	-	**119.4**
	Yorke, Lower North & Barossa	397	583	980	222	-	**1,202**	39.4	57.9	**97.4**	22.1	-	**119.4**
SOUTH AUSTRALIA TOTAL		7,908	8,018	**15,926**	3,000	90	**19,016**	46.1	46.8	**92.9**	17.5	0.5	110.9
WA	Goldfields	125	134	259	60	-	**319**	51.0	54.6	**105.6**	24.5	-	**130.0**
	Great Southern	288	357	645	140	-	**785**	40.6	50.3	**90.9**	19.7	-	**110.6**
	Kimberley	48	82	130	60	-	**190**	44.7	76.3	**120.9**	55.8	-	**176.7**
	Metropolitan East	1,164	1,299	2,463	442	-	**2,905**	46.8	52.2	**99.0**	17.8	-	**116.8**
	Metropolitan North	1,415	1,921	3,336	671	-	**4,007**	33.4	45.4	**78.8**	15.9	-	**94.7**
	Metropolitan South East	1,488	1,354	2,842	456	-	**3,298**	54.3	49.4	**103.6**	16.6	-	**120.3**
	Metropolitan South West	1,196	1,607	2,803	523	-	**3,326**	32.3	43.4	**75.8**	14.1	-	**89.9**
	Mid West	145	190	335	97	-	**432**	31.6	41.4	**72.9**	21.1	-	**94.0**
	Pilbara	30	20	50	50	-	**100**	48.8	32.5	**81.3**	81.3	-	**162.6**
	South West	410	575	985	185	-	**1,170**	34.9	48.9	**83.8**	15.7	-	**99.6**
	Wheatbelt	138	175	313	108	-	**421**	28.9	36.6	**65.5**	22.6	-	**88.1**
WESTERN AUSTRALIA TOTAL				**14,161**									

		6,447	7,714		2,792	-	**16,953**	39.3	47.0	**86.4**	17.0	-	103.4
TAS	North Western	490	456	946	202	-	**1,148**	43.0	40.0	**83.0**	17.7	-	**100.7**
	Northern	705	573	1,278	326	-	**1,604**	49.2	40.0	**89.2**	22.8	-	**111.9**
	Southern	1,078	1,088	2,166	460	-	**2,626**	44.9	45.3	**90.1**	19.1	-	**109.3**
TASMANIA TOTAL		2,273	2,117	**4,390**	988	-	**5,378**	45.7	42.5	**88.2**	19.9	-	108.1
NT	Alice Springs	100	56	156	191	-	**347**	104.3	58.4	**162.7**	199.2	-	**361.8**
	Barkly	17	2	19	42	-	**61**	146.6	17.2	**163.8**	362.1	-	**525.9**
	Darwin	157	123	280	282	-	**562**	47.4	37.2	**84.6**	85.2	-	**169.8**
	East Arnhem	5	6	11	72	-	**83**	36.5	43.8	**80.3**	525.5	-	**605.8**
	Katherine	27	41	68	78	-	**146**	67.3	102.2	**169.6**	194.5	-	**364.1**
NORTHERN TERRITORY TOTAL		306	228	**534**	665	-	**1,199**	62.2	46.3	**108.5**	135.1	-	243.6
ACT	Australian Capital Territory	663	931	1,594	466	-	**2,060**	30.7	43.1	**73.9**	21.6	-	**95.5**
AUSTRALIAN CAPITAL TERRITORY TOTAL		663	931	**1,594**	466	10	**2,070**	30.7	43.1	**73.9**	21.6	0.5	95.9
AUSTRALIAN TOTAL		80,052	83,380	**163,432**	33,671	100	**197,203**	42.3	44.1	**86.3**	17.8	0.1	104.2

Total Operational Places by Service Type as at 31 December 2005

Mainstream operational places (residential and community care places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	29,461	26,152	**55,613**	10,579		**66,192**
VIC	19,138	22,396	**41,534**	7,893		**49,427**
QLD	13,099	15,340	**28,439**	5,621		**34,060**
SA	7,755	7,852	**15,607**	2,786		**18,393**
WA	6,175	7,387	**13,562**	2,518		**16,080**
TAS	2,219	2,084	**4,303**	890		**5,193**
NT	261	174	**435**	559		**994**
ACT	663	931	**1,594**	416		**2,010**
Australia	78,771	82,316	**161,087**	31,262		**192,349**

National Aboriginal and Torres Strait Islander Aged Care Strategy operational places

(not allocated under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	6	15	**21**	34		**55**
VIC	15	10	**25**	69		**94**
QLD	41	32	**73**	6		**79**
SA	58	42	**100**	45		**145**
WA	6	8	**14**	2		**16**
TAS	-	-	**-**	41		**41**
NT	45	54	**99**	66		**165**
ACT	-	-	**-**	-		**-**
Australia	171	161	**332**	263		**595**

MPS operational places

(flexible places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	371	191	**562**	69		**631**
VIC	180	124	**304**	14		**318**
QLD	144	112	**256**	89		**345**
SA	95	124	**219**	14		**233**
WA	250	304	**554**	117		**671**
TAS	54	33	**87**	7		**94**
NT	-	-	**-**	-		**-**
ACT	-	-	**-**	-		**-**
Australia	1,094	888	**1,982**	310		**2,292**

Extended Aged Care at Home (EACH) operational places

(flexible places under the *Aged Care Act 1997*)

*EACH places are attributed as Community Care from 30 June 2004.

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW			**-**	569		569
VIC			**-**	478		478
QLD			**-**	339		339
SA			**-**	155		155
WA			**-**	155		155
TAS			**-**	50		50
NT			**-**	40		40
ACT			**-**	50		50
Australia			**-**	**1,836**		**1,836**

EACH Dementia operational places
(flexible places under the *Aged Care Act 1997*)
*EACH Dementia places are attributed as Community Care from 31 December 2005.

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW	0	0	**-**	0		**-**
VIC	0	0	**-**	0		**-**
QLD	0	0	**-**	0		**-**
SA	0	0	**-**	0		**-**
WA	0	0	**-**	0		**-**
TAS	0	0	**-**	0		**-**
NT	0	0	**-**	0		**-**
ACT	0	0	**-**	0		**-**
Australia	0	0	**0**	0		**0**

Innovative Care operational places
(flexible places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW			**-**			**-**
VIC			**-**			**-**
QLD			**-**			**-**
SA			**-**			**-**
WA	16	15	**31**	-	-	**31**
TAS			**-**			**-**
NT			**-**			**-**
ACT			**-**			**-**
Australia	16	15	**31**	-		**31**

Transition Care operational places
(flexible places under the *Aged Care Act 1997*)

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL
NSW			**-**		-	-
VIC			**-**		-	-
QLD			**-**		-	-
SA			**-**		90	**90**
WA			**-**		-	**-**
TAS			**-**		-	**-**
NT			**-**		-	**-**
ACT			**-**		10	**10**
Australia			**-**	**-**	**100**	**100**

Offline places by State / Territory

as at 31 December 2005

State / Territory	High care	Low care	Total Residential	Community Care	Transition Care	TOTAL PLACES	% of Total
NSW	629	409	**1,038**	-	-	**1,038**	**39.1%**
VIC	450	513	**963**	-	-	**963**	**36.2%**
QLD	173	80	**253**	7	-	**260**	**9.8%**
SA	67	11	**78**	-	-	**78**	**2.9%**
WA	141	168	**309**	-	-	**309**	**11.6%**
TAS	-	-	**-**	-	-	**-**	**0.0%**
NT	-	-	**-**	-	-	**-**	**0.0%**
ACT	-	10	**10**	-	-	**10**	**0.4%**
Australia	1,460	1,191	**2,651**	7	-	**2,658**	**100.0%**

Note: Table includes flexible care places: Extended Aged Care at Home (EACH), EACH Dementia, Multipurpose Services (MPS), permanently allocated Innovative Care (IC) places and places under the National Aboriginal and Torres Strait Islander Aged Care Strategy (ATSI). EACH and EACH Dementia places are attributed as community care while MPS, IC and ATSI flexible care places are attributed as high care, low care and community care packages.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-048

OUTCOME 3: Aged Care and Population Ageing

Topic: NATIONAL AGED CARE ADVOCACY SERVICE

Written Question on Notice

Senator McLucas asked:

(a) In 2003-04 the National Aged Care Advocacy Service undertook 4335 advocacy cases. Is there a report available on the nature of these advocacy cases and if so, can it be provided?

Answer:

(a) Information relating to the activity of the National Aged Care Advocacy Services in 2003-04 was published in the Department's "Report on the Operation of the *Aged Care Act 1997* 1 July 2004 to 30 June 2005" which is available on the Department's web site. In addition, the Services reported to the Department that, of the advocacy cases dealt with in 2003-04:

- 56% involved the advocacy service assisting someone to advocate on behalf of the aged care recipient;
- 29% involved the advocacy service directly representing the consumer/aged care recipient; and
- 15% involved the advocacy service assisting the consumer/aged care recipient to self-advocate.

The most common issues raised by consumers in 2003-04 in seeking advocacy were:

- choice/decision making;
- fees/charges;
- access to appropriate care;
- bonds; and
- security of tenure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-040

OUTCOME 3: Aged Care and Population Ageing

Topic: GRACE OF MARY GREEK CYPRIOT HOSTEL

Written Question on Notice

Senator McLucas asked:

(a) Sanctions were applied to the Grace of Mary Greek Cypriot Hostel on October 14 2005. What caused the ACSAA to visit this aged care facility. Was it because of complaints, and what was the nature of the complaints?

(b) Has this facility had a totally unannounced spot check since it was first accredited?

(c) If not, why not?

Answer:

(a) The Aged Care Standards and Accreditation Agency had placed the home on a Timetable for Improvement due to previously identified non-compliance. As part of a scheduled support contact visit on 4 October 2005, the Agency identified further non-compliance and made the decision to undertake a review audit. The visits undertaken by the Agency were not as a result of complaints.

(b) Yes. Authorised officers of the Department of Health and Ageing have made three unannounced spot checks to the home.

(c) See answer to (b).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-129

OUTCOME 3: Aged Care and Population Ageing

Topic: STATE, TERRITORY AND LOCAL GOVERNMENTS FIRE STAFETY STANDARDS

Hansard Page: CA 57

Senator McLucas asked:

Can we have the names of the 10 facilities that did not fall within the accreditation certification process, the date they will be compliant and the date you were advised that they were not compliant.

Answer:

This information is considered protected information under section 86-1 of the *Aged Care Act 1997* (the Act).

The Department became aware of the homes on receipt of their 2004 Fire Safety Declaration in March 2005. The number of homes which have yet to declare to the Department that they meet state/territory and local government fire safety regulations from that Declaration is now six.

The Department has ensured that the relevant approved providers have informed all residents of these homes of the situation at their respective homes and the plans the homes have to meet requirements.

All homes were referred to the Aged Care Standards and Accreditation Agency and have been placed on Timetables for Improvement.

All six homes are certified and accredited, therefore they remain eligible to receive accommodation bonds and/or charges from residents and Australian Government subsidy payments.

All of the homes provided the Department with their plan and timetable to meet state/territory and local government fire safety regulations. The Department is continuing to monitor the situation closely.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-033

OUTCOME 3: Aged Care and Population Ageing

Topic: NURSING HOMES – ACCREDITATION AND CERTIFICATION

Written Question on Notice

Senator McLucas asked:

(a) What section of the Aged Care Act 1997 precludes the Department of Health and Ageing from advising the Community Affairs Committee of the names of the eight aged care facilities that do not fall within the accreditation and certification process, the four in NSW, three in Western Australia and the one in Victoria?

(b) When did each of them fail the state/local Government certification process?

(c) Have any of them had their accreditation reviewed, and if not, why not?

(d) Given these eight facilities would now not comply with aged care certification, how are they able to receive Government funding?

(e) What is the Department planning to do in relation to each of these facilities?

Answer:

(a) Section 86-1 of the *Aged Care Act 1997* (the Act).

(b) The Department became aware of the homes on receipt of their *2004 Fire Safety Declaration* in March 2005. The Declaration requires approved providers to declare whether their home did not meet state, territory or local government fire safety standards at any time during the previous twelve months.

(c) All of the homes were referred to the Aged Care Standards and Accreditation Agency in December 2005 and have since been placed on Timetables for Improvement.

(d) All of the homes are certified and accredited, therefore they remain eligible to receive accommodation bonds and/or charges from residents and Australian Government subsidy payments.

(e) All eight homes provided the Department with their plan and timetable to meet state/territory and local government fire safety regulations. Two homes have advised the Department that they now meet state/territory and local government fire safety regulations and there are now only six homes that are still to meet the regulations. The Department is continuing to monitor the situation closely.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-036

OUTCOME 3: Aged Care and Population Ageing

Topic: SPOT CHECKS

Written Question on Notice

Senator McLucasasked:

(a) In the 2004/05 report of the operation of the Aged Care Act, the Agency and the Department conducted a total of 4705 visits in 04/05. Of these, only 563 were spot checks. How many of them were totally unannounced?

(b) Who decides when a totally unannounced spot check is undertaken and on what criteria? Is it ACSAA or the Department?

(c) Please provide the numbers of unannounced visits by State and Territory with notice of less than a day, and, without any notice at all, in the years 2002-03, 2003-04, 2004-05, 2005 to date.

Answer:

(a) An unannounced visit is a visit conducted with less than 30 minutes' notice. The Agency does not record the actual period of notice when less than 30 minutes' notice is given. The *Accountability Principles 1998* s1.7 require that Agency assessors must give the approved provider of the home written notice of a visit.

The Agency arranges random and targeted unannounced visits. They can either be support contacts or review audits, where homes are given less than 30 minutes' notice. Around 13 per cent, or 563, of the Agency's support contact visits and review audits were conducted unannounced in 2004/05.

(b) The Agency determines when a visit will be made. The decision takes into account relevant information including whether there is information obtained by the Agency that indicates that an unannounced visit is appropriate.

(c) The number of support contact and review audits conducted with less than one day's notice was as follows:-

	NSW	ACT	Vic	Tas	Qld	SA	NT	WA	Aust
2002/03	Breakdown not available								**NA**
2003/04	Breakdown not available								**NA**
2004/05	180	1	306	17	94	80	0	56	**734**
2005/06 to end Dec 2005	89	4	193	14	55	30	0	21	**406**

The number of unannounced support contact and review audits recorded was as follows:-

	NSW	ACT	Vic	Tas	Qld	SA	NT	WA	Aust
2002/03	Breakdown not available								**242**
2003/04	202	*	236	*	57	27	*	31	**553**
2004/05	139	1	236	14	73	57	0	43	**563**
2005/06 to end Dec 2005	76	3	164	12	45	22	0	18	**340**

***In 2003/2004:**

The Tasmania figures are included in the Victoria figures (as the Victoria office looks after Tasmania);
The Northern Territory figures are included in the South Australia figures (as SA office looks after NT); and
The ACT figures are included in the NSW figures (as NSW office looks after ACT).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-037

OUTCOME 3: Aged Care and Population Ageing

Topic: SPOT CHECKS

Written Question on Notice

Senator McLucas asked:

(a) How many totally unannounced spot checks did Barton Vale have between April 05 and November 05.

(b) The Accreditation Agency recommended that accreditation of Barton Vale be revoked. Why did the Department not do this? Is the advice (Brandon) to the Committee correct?

(c) Another facility, St David's nursing home was owned by the same provider as Barton Vale, was closed down in 2003. There is a sanctions report from 2001. Did this facility have a review audit in 2003 and what were the findings?

(d) Was the facility closed down by the Department, or voluntarily because they lost their accreditation?

(e) What happened with this facility during and after the December 2001 review audit?

(f) If this facility did lose accreditation, please explain why.

(g) What happened to the residents of St David's?

(h) How many totally unannounced spot checks have been made on Marron from 2003 until present?

Answer:

(a) An unannounced support contact was conducted on 5 October 2005.

An unannounced review audit was conducted over the period 17-24 October 2005.

The approved provider was notified within 30 minutes of the visit in writing. The *Accountability Principles 1998* require notification in writing.

(b) The information provided to the Committee is correct. The Agency does not make recommendations concerning revocation to the Department. It makes decisions concerning revocation. In this case it made the decision to reduce the period of accreditation.

Under the *Accreditation Grant Principles 1999*, an independent assessment team is created for the purpose of conducting an assessment. The team is then disbanded after providing their report and recommendations to the Agency. The team is required to make recommendations concerning accreditation. In this case the assessment team recommended revocation to the Agency.

In making the accreditation decision, the accreditation body (the Agency) must take into account the report of the assessment team, information (if any) received from the Secretary of the Department of Health and Ageing; information (if any) received from the applicant; whether it is satisfied that the residential care service will undertake continuous improvement. (see *Accreditation Grant Principles 1999* s2.27 (3))

In this case, the Agency decided to reduce the home's period of accreditation so that it will expire on 29 May, 2006. Previously, its accreditation was due to expire on 24 June, 2008.

(c) There was no review audit conducted in 2003.

(d) The service was accredited at the time of closure.

(e) The service did not have a review audit in December 2001.

(f) Refer to response to (d).

(g) Refer to response to E06-109.

(h) Two unannounced visits have been conducted in this period.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-039

OUTCOME 3: Aged Care and Population Ageing

Topic: JOHN CANI ESTATE

Written Question on Notice

Senator McLucasasked:

(a) The John Cani Estate Hostel was found to fail 11 out of 44 expected outcomes in November 2005. What caused the ACSAA to visit this aged care facility? Was it because of complaints, and what was the nature of the complaints?

(b) Has this facility had a totally unannounced spot check since it was accredited on 9 December 2001?

(c) If not, why not?

Answer:

(a) The Agency had planned to visit the home in November 2005 as part of its ongoing monitoring of the home. Prior to that visit occurring, the Department of Health and Ageing requested that the Agency carry out a review audit under section 3.21(6) of the Accreditation Grant Principles, 1999.

(b) There have been two unannounced visits (visits with less than 30 minutes' notice) since the home was accredited (these were in 2005 and 2006). The *Accountability Principles 1998* s 1.7 require that Agency assessors must give the approved provider of the home written notice of a visit. Refer response to question E06-036.

(c) See (b).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-046

OUTCOME 3: Aged Care and Population Ageing

Topic: AUSTRALIAN GOVERNMENT EXPENDITURE: AGED CARE PLACES

Written Question on Notice

Senator McLucas asked:

(a) Could you provide a table that shows Commonwealth expenditure per high care and low care residential aged care place and community care place from 1990 to 2005 in 2005 dollars.

(b) Could you provide a table that shows Commonwealth residential aged care and community care expenditure per person aged over 70 years for the period 1990 to 2005.

Answer:

(a) The table below provides estimated average recurrent expenditure per permanent high care or low care resident or community care recipient in 2004-05 dollars.

The calculations for expressing previous years' annual expenditure in 2004-05 dollars used a combination of the most recent release (September Quarter 2005) of the Non-farm GDP Implicit Price Deflator used by the Australian Bureau of Statistics in its Australian National Accounts (ABS 5206.0) for the years 1990-91 to 1995-96 inclusive and a deflator calculated from the values of Wage Cost Index 9 (WCI9) for the years 1996-7 to 2003-04. WCI9 was the basis of indexation of aged care payments from 1996-7 to 2004-05.

	Residential high care (1)	Residential low care (1)	Community Aged Care Packages (2)	Extended Aged Care at Home (2)
1990-91	$29,134	$5,579	n.a.	n.a.
1991-92	$28,958	$6,442	(3)	n.a.
1992-93	$29,176	$6,490	(3)	n.a.
1993-94	$29,783	$6,723	(3)	n.a.
1994-95	$30,246	$8,193	$11,286	n.a.
1995-96	$32,702	$8,692	$11,218	n.a.
1996-97	$34,641	$9,358	$11,170	n.a.
1997-98	$36,829	$11,214	$11,559	n.a.
1998-99	$39,175	$13,090	$11,521	n.a.
1999-00	$40,265	$13,268	$11,487	n.a.
2000-01	$40,572	$13,430	$11,561	n.a.
2001-02	$41,241	$13,886	$11,573	n.a.
2002-03	$42,369	$14,269	$11,658	n.a.
2003-04	$42,390	$14,515	$11,705	$39,169
2004-05	$42,879	$15,563	$11,695	$39,093

Notes:

(1) Includes expenditure funded from the Veterans' Affairs portfolio. For 1990-91 to 1996-97, the figures are based on recurrent expenditure for Nursing Home benefits or Hostel Benefits respectively, divided by an estimate of the average number of residents for the year. For 1998-99 onwards, the figures are based on recurrent payments for residential aged care subsidies and supplements attributed to high care or low care on the basis of the classification of the residents according to the Resident Classification Scale. Figures cannot be calculated for 1997-98 due to the conversion of the payments systems as part of the initial implementation of the *Aged Care Act 1997*. The 1997-98 figures are based on averages of the preceding and following years.

(2) Based on the annual subsidy rate for Community Aged Care Packages or Extended Aged Care at Home packages.

(3) The small number of Community Aged Care Packages and frequent changes in the number of places in operation prevents calculation of a meaningful average cost per care recipient for these years.

(b) Annual expenditure per person aged 70 plus at 30 June 2005.

	Residential aged care (1)	Community aged care places (2)
1990-91	$1,425	n.a.
1991-92	$1,436	(3)
1992-93	$1,475	(3)
1993-94	$1,464	(3)
1994-95	$1,514	$12
1995-96	$1,630	$22
1996-97	$1,733	$33
1997-98	$1,880	$53
1998-99	$2,026	$74
1999-00	$2,103	$87
2000-01	$2,130	$109
2001-02	$2,221	$140
2002-03	$2,351	$158
2003-04	$2,741	$176
2004-05	$2,732	$191

(1) See note (1) for answer (a) above.

(2) Community Aged Care Packages and Extended Aged Care at Home Packages.

(3) The small number of Community Aged Care Packages and frequent changes in the number of packages in operation prevents calculation of a meaningful average cost per care recipient for these years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-054

OUTCOME 3: Aged Care and Population Ageing

Topic: AGED CARE PROGRAMS - BUDGET

Senator McLucas asked:

(a) List all programs that go to make up each output in Outcome 3 in the 2005-06 Additional Estimates Portfolio Budget Statement;
(b) For each of those programs in (a) what are the most recent estimates of program spending or revenue for 2005-06, 2006-07, 2007-08 and 2008-09;
(c) For each of those programs in (a) what were the financial outcomes for each in 2002-03, 2003-04 and 2004-05;
(d) For each of those programs in (a) what are the dollar amounts for 2005-06, 2006-07, 2007-08 and 2008-09 that are obligated or otherwise forward committed, contractually or otherwise; and
(e) What indexation arrangements and guarantees will be put in place to ensure programs are no worse off once SNA are abolished?

Answer:

(a) Administered funding is reported at a program group level. For Outcome 3 there are eight different program groups. These are outlined in Attachment A.

(b) The Department of Health and Ageing provides financial reports at a program group level. The Department of Finance and Administration restricts the release of forward estimates at the program level. Attachment B provides current 2005-06 estimates.

(c) Attachment C provides actual expenditure for Bills 1/3 and 2/4 and Special Appropriations for each program group. Note that the program group structure changed in 2005-06.

(d) Refer to Attachment C.

(e) The future basis of indexation is a policy matter for the Government. The Government has not yet advised what the future basis of indexation will be. The Minister for Finance and Administration has stated that it cannot be assumed that future indexation arrangements will be less generous than existing arrangements.

Attachment A

Within the eight different program groups, the following programs are funded

Program 3.1: Aged Care Assessment – includes funding for Aged Care Assessment and GST Assessment of Retirement Villages;

Program 3.2: Aged Care Workforce – includes funding for More Aged Care Nurses, Support for Aged Care Training and Better Skills for Better Care;

Program 3.3: Ageing Information and Support – includes funding for Implementation and Communication, Commonwealth Carelink programs, Community Visitors Scheme & Advocacy Services and Complaints Resolution Scheme;

Program 3.4: Community Care – includes funding for Community Aged Care Packages (CACP), CACP Establishment Grants, Carers Information and Support, Day Therapy Centres, Housing & Care Linkages, Safe at Home, Reforms in Community Care, Respite for Carers, National Continence Management Scheme, Continence Aids Assistance Scheme, Macular Degeneration Foundation, HACC Planning & Development and Home and Community Care Programs;

Program 3.5: Culturally Appropriate Aged Care – includes funding for Aboriginal and Torres Strait Islander (ATSI) Assistance Packages, ATSI Flex Service Model Grant, ATSI Flex Service Model Recurrent, Cultural Linguistical Diverse Background, Aged Care for Establishment Diverse Communities, FBT Supplementation for ATSI Organisations;

Program 3.6: Dementia – includes funding for Psychogeriatric Units, Dementia Education & Support Programme, Dementia - A National Health Priority, Dementia Training and Dementia Extended Aged Care at Home.

Program 3.7: Flexible Aged Care – includes funding for Extended Aged Care at Home, Innovative Pool, Multi Purpose Services, Retirement Villages and Transition Care Program; and

Program 3.8: Residential Care – includes funding for Residential Care Subsides, Aged Care Accreditation Agency, Aged Care Standards Accreditation Agency Small Homes Subsidy, Targeted Capital Assistance and Rural and Remote Building Fund.

Outcome 3 - Financial Resources Summary

	As at AEs 2005-06 $'m
Administered appropriations	
Program 3.1: Aged Care Assessment	
Appropriation Bill 1/3	4.401
Appropriation Bill 2/4	55.461
TOTAL 3.1	**59.862**
Program 3.2: Aged Care Workforce	
Appropriation Bill 1/3	32.814
TOTAL 3.2	**32.814**
Program 3.3: Ageing Information and Support	
Appropriation Bill 1/3	38.634
TOTAL 3.3	**38.634**
Program 3.4: Community Care	
Aged or Disabled Persons Care Act 1954 and *Aged Care Act 1997* - Community Care Subsidies	364.520
Appropriation Bill 1/3	206.072
Appropriation Bill 2/4	857.835
TOTAL 3.4	**1,428.427**
Program 3.5: Culturally Appropriate Aged Care	
Appropriation Bill 1/3	20.611
TOTAL 3.5	**20.611**
Program 3.6: Dementia	
Appropriation Bill 1/3	27.550
TOTAL 3.6	**27.550**
Program 3.7: Flexible Aged Care	
Aged Care Act 1997 - Flexible Care Subsidies	180.313
Total Special Appropriations	**180.313**
TOTAL 3.7	
Program 3.8: Residential Care	
Aged Care Act 1997 - Residential Care Subsidies	

	4,518.372
Appropriation Bill 1/3	54.044
TOTAL 3.8	**4,572.416**
Total administered appropriations	**6,360.627**

Outcome 3 - Financial Resources Summary

Administered Expenses	Actual 2002-03 $'000	Actual 2003-04 $'000	Actual 2004-05 $'000
Administered Item 1: Residential Care Subsidies			
Aged Care Act 1997 -Residential Care Subsidies	3,669,475	3,918,551	4,271,234
Aged Care Consequential Provisions Act 1997 -Contribution to Building Safety		518,747	152,018
Total Special Appropriations	3,669,475	4,437,298	4,423,252
Appropriation Bill 1/3	48,663	46,251	58,840
Total Administered Item 1	**3,718,138**	**4,483,549**	**4,482,092**
Administered Item 2: Community Care and Support for Carers			
Aged Care Act 1997 -Community Care Subsidies	288,359	307,759	327,770
Total Special Appropriations	288,359	307,759	327,770
Appropriation Bill 1/3	143,591	152,566	156,034
Appropriation Bill 2/4	674,086	732,388	791,858
Total Administered Item 2	**1,106,036**	**1,192,713**	**1,275,662**
Administered Item 3: Ageing Support and Strategies			
Aged Care Act 1997 - Flexible Care Subsidies	51,783	79,378	114,561
Total Special Appropriations	51,783	79,378	114,561
Appropriation Bill 1/3	39,153	41,616	58,545
Appropriation Bill 2/4	42,896	48,301	52,883
Total Administered Item 3	**133,832**	**169,295**	**225,989**
Total Administered Expenses	**4,958,006**	**5,845,557**	**5,983,743**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-042

OUTCOME 3: Aged Care and Population Ageing

Topic: AGED CARE PLACES BY STATISTICAL LOCAL AREA

Senator McLucas asked:

On 16 December we asked the Ageing Minister on notice to provide:

— For each Statistical Local Area for the whole of Australia: what are the numbers of operational and provisionally-allocated residential aged care low care beds and high care beds, and Community Aged Care and Extended Aged Care at Home packages.
— In which Aged Care Planning region does each Statistical Local Area fall.

The answer from Senator Santoro was:
(1) and (2) An aged care planning ratio was first adopted in 1985, at 100 places per thousand persons aged 70 years and over. At the same time a set of aged care planning regions was also established. Since that time, aged care places have been allocated to aged care planning regions and not on the basis of statistical local areas.

In 2003 in response to a question on notice asking for operational aged care beds by postcode, the then Ageing Minister Kevin Andrews said: "As postcodes and suburbs can overlap Aged Care Planning Regions they are not used in the calculation of aged care provision in a region. An aged care home which is in one postcode area may not be part of the same Aged Care Planning Region as other homes in the same postcode area. Aged Care Planning Regions are based on groupings of Statistical Local Areas (SLAs). In answering the question, place numbers in each SLA will be provided."

If a former Ageing Minister was able to answer this question in 2003, why is the Department unable to supply this information now? I again ask the Department to please provide this information.

(a) For each Statistical Local Area for the whole of Australia: what are the numbers of operational and provisionally-allocated residential aged care low care beds and high care beds, and Community Aged Care and Extended Aged Care at Home packages.
(b) In which Aged Care Planning region does each Statistical Local Area fall.

Answer:

(a) and (b).

There are 1,353 Statistical Local Areas (SLA), which are too small and too numerous for use as the basis for effective planning of aged care. Moreover, some are densely populated and others are virtually unpopulated. In general, individual SLAs do not equate to service catchments. The basic geographic units used for planning, allocation of places, and reporting are the Aged Care Planning Regions.

The table below lists each Aged Care Planning Region by state or territory and shows the number of (a) operational places and (b) all places, including operational, provisionally allocated and offline places, for high and low care residential care, Community Aged Care Packages and Extended Aged Care at Home packages in the region as at 30 June 2005. Transition care places are shown for each state or territory. Flexible care places are included, attributed as residential or community care.

Operational and all aged care places by state or territory and aged care planning region, as at 30 June 2005.

State	Aged Care Planning Region	(a) Operational places				(b) All places (including operational, provisionally allocated and offline places)				
		Residential		Community Care		Residential		Community Care		Transition Care
		High	Low	CACP	EACH	High	Low	EACH	CACP	
NSW	All state									173
NSW	Central Coast	1,543	1,443	701	40	1,660	2,059	65	826	
NSW	Central West	794	897	274	10	789	941	25	320	
NSW	Far North Coast	1,278	1,507	585	30	1,498	1,932	60	665	
NSW	Hunter	2,480	2,578	926	40	2,752	3,150	75	1,103	
NSW	Illawarra	1,409	1,476	697	68	1,712	2,366	93	862	
NSW	Inner West	3,127	1,458	724	30	3,259	1,677	30	759	
NSW	Mid North Coast	1,300	1,683	651	60	1,682	2,259	70	781	
NSW	Nepean	1,229	712	344	15	1,251	957	30	389	
NSW	New England	740	870	323	10	829	992	10	356	
NSW	Northern Sydney	4,517	3,952	1,126	48	4,656	4,300	73	1,345	
NSW	Orana Far West	536	809	349	10	596	919	25	360	
NSW	Riverina/Murray	980	1,244	444	35	1,210	1,510	50	499	
NSW	South East Sydney	3,537	2,401	1,467	55	3,886	3,691	105	1,556	
NSW	South West Sydney	2,717	2,100	957	70	2,814	2,968	70	1,102	
NSW	Southern Highlands	704	1,062	333	13	844	1,317	18	403	
NSW	Western Sydney	2,802	1,718	772	30	2,858	2,262	60	900	
Vic	All state									150
Vic	Barwon-South Western	1,633	1,865	730	30	1,853	2,182	30	805	
Vic	Eastern Metro	3,723	4,598	1,408	92	4,321	5,370	157	1,773	
Vic	Gippsland	943	1,329	458	30	1,221	1,524	60	538	
Vic	Grampians	921	1,104	404	43	1,026	1,253	43	444	
Vic	Hume	1,064	1,281	465	15	1,202	1,537	45	535	

Vic	Loddon-Mallee	1,313	1,570	541	46	1,404	1,811	56	611	
Vic	Northern Metro	2,891	2,844	1,213	70	3,476	3,600	110	1,398	
Vic	Southern Metro	4,655	5,222	1,838	75	5,550	6,283	135	2,169	
Qld	Western Metro	1,838	2,243	889	62	2,310	2,822	82	991	
Qld	All state									106
Qld	Brisbane North	2,019	1,980	565	30	2,180	2,100	50	670	
Qld	Brisbane South	2,467	2,552	734	30	2,775	2,831	40	934	
Qld	Cabool	978	1,113	303	20	1,179	1,399	30	438	
Qld	Central West	63	49	61		63	49		61	
Qld	Darling Downs	951	1,119	362	10	1,029	1,159	20	387	
Qld	Far North	608	779	364	30	660	838	30	390	
Qld	Fitzroy	560	742	267	10	663	794	30	287	
Qld	Logan River Valley	380	544	232	16	632	898	35	262	
Qld	Mackay	350	389	161	10	364	437	20	161	
Qld	North West	46	78	90	4	59	78	4	95	
Qld	Northern	689	779	243	15	784	787	25	278	
Qld	South Coast	1,421	1,817	537	20	1,888	2,245	55	764	
Qld	South West	72	149	97		74	149		97	
Qld	Sunshine Coast	1,158	1,510	461		1,472	1,931	40	631	
Qld	West Moreton	481	675	168		491	738	20	203	
Qld	Wide Bay	886	1,073	373		1,080	1,272	40	445	
Qld	All state									90
Qld	Eyre Peninsula	103	185	83		125	182		83	
Qld	Hills, Mallee & Southern	485	568	215	20	567	613	27	268	
Qld	Metropolitan East	2,280	1,878	430	35	2,286	1,882	35	528	
Qld	Metropolitan North	1,151	974	344	39	1,458	1,185	39	373	
Qld	Metropolitan South	1,593	1,617	685	8	1,733	1,829	34	768	
Qld	Metropolitan West	1,234	1,162	508	25	1,254	1,286	47	538	
Qld	Mid North	65	214	64	3	69	227	8	79	

Qld	Riverland	146	238	83		146	238	10	108	
Qld	South East	177	297	94	10	189	358	10	128	
Qld	Whyalla, Flinders & Far North	133	195	123	5	142	209	10	143	
SA	Yorke, Lower North & Barossa	379	566	212	10	398	583	10	226	
WA	All state									50
WA	Goldfields	124	134	60		148	134		69	
WA	Great Southern	275	346	127		288	388		162	
WA	Kimberley	56	82	53		68	92		60	
WA	Metropolitan East	1,164	1,280	415	21	1,196	1,385	80	430	
WA	Metropolitan North	1,426	1,910	581	64	1,737	2,349	55	727	
WA	Metropolitan South East	1,480	1,354	438	50	1,626	1,477	55	552	
WA	Metropolitan South West	1,126	1,562	468	20	1,504	1,792	45	590	
WA	Mid West	145	190	97		150	221		121	
WA	Pilbara	30	20	50		30	53		50	
WA	South West	406	573	185		472	704		260	
WA	Wheatbelt	121	170	79		138	175		118	
Tas	All state									20
Tas	North Western	488	454	197		500	511		227	
Tas	Northern	695	571	286	23	814	643	23	313	
Tas	Southern	1,072	1,069	413	27	1,185	1,179	52	463	
NT	Alice Springs	100	56	173	10	110	56	15	181	
NT	Barkly	17	2	38		17	2		42	
NT	Darwin	157	123	242	30	169	131	45	262	
NT	East Arnhem	5	6	65		5	6		72	
NT	Katherine	27	36	55		27	41		78	
ACT	ACT	638	918	416	50	918	1,308	70	471	
ACT	All state									10

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-045

OUTCOME 4: Primary Care

Topic: MEASURE OF GP VISITS TO AGED CARE FACILITIES – ADOPT A GP

Written Question on Notice

Senator McLucas asked:

a) In a media release on 6 November 2005, the then Ageing Minister Julie Bishop said "many more local GPs than before are working with aged care homes to boost the access of residents to quality medical care" after the introduction of the "adopt-a-GP" scheme. How does the Department actually measure if there are more GP visits to aged care facilities?

b) If there are any data on this, can this be provided?

Answer:

a) The Department collects data on the Aged Care GP Panels initiative from Divisions of General Practice on a six monthly basis. Data collected includes:
   i. the number of operating Panels;
   ii. the number of participating GPs; and
   iii. the number of participating aged care homes.

   The Department also collects data on GP visits through Medicare including:
   i. the number of GPs visiting aged care homes; and
   ii. the number of aged care homes Medicare Benefits Schedule (MBS) attendance items claimed.

b)

Aged Care GP Panels initiative data

	Number of Panels	Number of GPs	Number of Aged Care Homes
1 July 2004 – 31 December 2004	169	870	1100
1 January 2005 – 30 June 2005	267	1379	1760

Medicare Data

Financial Year	No. of GPs attending aged care homes	No. of services in aged care homes claimed through Medicare Australia
2003/04	12,278	1,754,688
2004/05	12,480	1,849,418

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, February 2006

Question: E06-071

OUTCOME 4: Primary Care

Topic: PRACTICE INCENTIVES PROGRAM (PIP) ASTHMA INCENTIVE

Hansard Page: CA 85

Senator Crossin asked:

Would you have any idea how many actually access the (Asthma 3+) financial incentives through PIP?

Answer:

Under the Practice Incentives Program (PIP), Aboriginal Community Controlled Health Services (ACCHS) are not required to identify themselves. However, in the 27 Divisions of General Practice with an Indigenous Australian population of 1% or more, around 1,120 practices are participating in the PIP. Of these, 970 practices, with 4,372 GPs, have signed on for the asthma incentive. In the November 2005 quarter, 1,390 service incentive payments were made for completed Asthma 3+ Plans.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-072

OUTCOME 4: Primary CareTopic: ACCREDITATION OF DIVISIONS OF GENERAL PRACTICE

Hansard Page: CA 73

Senator Forshaw asked:

How many of the Divisions have already become accredited?

Answer:

17 Divisions have become accredited with the remainder having commenced the accreditation process.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-125

OUTCOME 4: Primary Care

Topic: RURAL GP WORKFORCE

Hansard Page: CA 78

With regards to figures for rural and remote GPs by FWE from 1995-96 to 2004-05, Senator McLucas asked:

Is it possible to provide a photocopy of them to the committee?

Answer:

See attached table – General Practice Workforce, 1995-96 to 2004-05.

General Practice Workforce, 1995-96 to 2004-05

YEAR	Urban		Rural and Remote		National	
	Headcount	FWE	Headcount	FWE	Headcount	FWE
1995-96	18,959	12,501	5,417	3,551	24,376	16,051
1996-97	18,937	12,719	5,589	3,596	24,526	16,316
1997-98	18,524	12,791	5,706	3,641	24,230	16,432
1998-99	18,208	12,754	5,968	3,635	24,176	16,389
1999-00	18,024	12,761	6,210	3,672	24,234	16,433
2000-01	17,905	12,668	6,363	3,825	24,268	16,493
2001-02	17,719	12,731	6,588	4,005	24,307	16,736
2002-03	17,521	12,654	6,739	4,118	24,260	16,772
2003-04	17,482	12,608	6,841	4,263	24,323	16,872
2004-05	17,722	12,856	6,947	4,416	24,669	17,273
% change on previous year						
1996-97	-0.1%	1.7%	3.2%	1.3%	0.6%	1.6%
1997-98	-2.2%	0.6%	2.1%	1.2%	-1.2%	0.7%
1998-99	-1.7%	-0.3%	4.6%	-0.2%	-0.2%	-0.3%
1999-00	-1.0%	0.1%	4.1%	1.0%	0.2%	0.3%
2000-01	-0.7%	-0.7%	2.5%	4.2%	0.1%	0.4%
2001-02	-1.0%	0.5%	3.5%	4.7%	0.2%	1.5%
2002-03	-1.1%	-0.6%	2.3%	2.8%	-0.2%	0.2%
2003-04	-0.2%	-0.4%	1.5%	3.5%	0.3%	0.6%
2004-05	1.4%	2.0%	1.5%	3.6%	1.4%	2.4%
% change on 1995-96						
2003-04	-7.8%	0.9%	26.3%	20.1%	-0.2%	5.1%
2004-05	-6.5%	2.8%	28.2%	24.4%	1.2%	7.6%

Explanatory Notes

GP headcount A count of all GPs who have provided at least one Medicare Service during the reference period. Note that the headcount figure includes several thousand medical practitioners who provide only small numbers of services through Medicare each Year.

FWE (Full-Time Workload Equivalent) FWE is a measure of service provision that adjusts for variations in the work practice of GPs. It is generally considered to be a better overall indicator of medical workforce supply than headcounts.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-114

OUTCOME 5: Rural Health

Topic: RURAL HEALTH STRATEGY – BUILDING HEALTHY COMMUNITIES IN REMOTE AUSTRALIA PROGRAM

Hansard Page: CA 123

Senator McLucas asked:

(a) I wonder if you could give the committee a list of those 18 projects that are under way
(b) And a bit of an indication of what is intended to be achieved, the funding allocation to each and perhaps the auspicing body as well.

Answer:

Details of the 18 projects currently being funded are provided at Attachment A.

Auspice Organisation	Communities in which project will be undertaken	Total funding allocation (GST inc)	Project goals
New South Wales			
Condoblin Aboriginal Health Service	Murrin Bridge and Lake Cargelligo, NSW	$300,000	○ To improve the primary health of the Aboriginal communities of the project area with a focus on healthy lifestyles, smoking and harmful alcohol consumption and good nutrition and healthy weight.
Maari Ma Aboriginal Health Corporation	Ivanhoe, Tibooburra and Menindee, NSW	$527,077	○ To increase the capacity of community members and organisations working with children to address identified health issues; ○ To prevent/reduce nutritional disorders in children aged 0-12 years; and ○ To reduce the risk of obesity and health problems including heart disease and Type 2 diabetes.
NSW Outback Division of General Practice Ltd	Enngonia and Weilmoringle, NSW	$328,900	○ To increase physical activity and healthy nutrition within the project communities.
Northern Territory			○
Anyinginyi Health Aboriginal Corporation	Tennant Creek and Wogyala, NT	$300,000	Using a specific program of community-based activities to: ○ Improve nutrition among children and young people; ○ Improve parenting skills of young mothers; ○ Improve positive life skills and increase understanding about sexual health, and drug and alcohol misuse among young people; and ○ Reduce the incidence of smoking tobacco amongst staff in Anyinginyi Health Aboriginal Corporation.
Menzies School of Health Research	Galiwin'ku, Elcho Island, NT	$300,000	○ To increase consumption of fresh fruit and vegetables and enable healthy food choices in the population; ○ To reduce the risk of diabetes and cardiovascular disease through a coordinated and strategic approach to food security and the development of community food policy; and ○ To develop a project with the potential to be translated to neighbouring communities of the same language groups.

Auspice Organisation	Communities in which project will be undertaken	Total funding allocation (GST inc)	Project goals
Queensland			
Royal Flying Doctor Service of Australia (Queensland)	Georgetown, Chillagoe, Croydon and Coen, Qld	$377,579	○ To create a sustainable model of community based healthy lifestyle promotion in four remote communities using a Healthy Towns Challenge.
Qld Health-Torres Strait and Northern Peninsula Area Health Service District	Torres Strait: five island clusters and five communities on the Northern Peninsula Area, Qld	$300,000	○ To decrease the prevalence of chronic disease and preventable complications, measured by a decrease in diabetes related hospitalisation rates and the reduction in the number of children aged 5- 17 years with chronic disease risk factors.
Qld Health-Torres Strait and Northern Peninsula Area Health Service District	Torres Strait: five island clusters and five communities on the Northern Peninsula Area, Qld	$300,000	○ To decrease the prevalence of chronic disease and preventable complications, measured by a decrease in diabetes related hospitalisation rates.
Southern Queensland Rural Division of General Practice	Charleville, Morven, Augathella, Quilpie, Cunnamulla, Thargomindah, Qld	$483,131	Using a specific program of community-based activities to: ○ Increase physical activity; ○ Improve nutrition; ○ Increase self management of chronic conditions through awareness and the transfer of skills and knowledge; and ○ Increase well being.

Auspice Organisation	Communities in which project will be undertaken	Total funding allocation (GST inc)	Project goals
South Australia			
Northern and Far Western Regional Health Service Inc	Andamooka, Roxby Downs & Woomera, SA	$308,000	Using a specific program of community-based activities to: o Increase participation in physical activity; o Improve participation of men in health promoting behaviour; o Increase health education for women; o Improve youth health awareness and education; and o Improve social emotional and wellbeing.
Northern and Far Western Regional Health Service Inc	Mintabie, Marla and Lambina, SA	$308,000	Using a specific program of community-based activities to: o Improve nutrition choices; o Increase awareness of mental health; o Increase participation in physical activities; o Reduce utilisation of smoking, drug and alcohol; and o Reduce number and impact of injuries.
Northern and Far Western Regional Health Service Inc	Nepabunna & Copley, SA	$308,000	o To improve the physical health of the community members with a focus on healthy lifestyles, reducing injury, reduction of smoking and harmful alcohol consumption, good nutrition and healthy weight and increasing levels of physical activity.
SA Dept of Health	Maree and stations, SA	$300,000	Using a specific program of community-based activities to : o Improve understanding of, and access to, healthy foods; o Reduce alcohol, substance misuse and smoking; o Increase the number of mothers adopting and maintaining healthy lifestyles; o Increase participation in physical activity and recreation; and o Improve key social determinants of good health.
SA Dept of Health	Oodnadatta, SA	$300,000	o To improve the physical health of the community members with a focus on increased fitness levels, weight loss, reduced levels of depression in the community and improved birth weight of newborns.

Auspice Organisation	Communities in which project will be undertaken	Total funding allocation (GST inc)	
Western Australia			
Ngagganawili Aboriginal Community Controlled Health & Medical Service Aboriginal Corporation (NACCH&MSAC)	Wiluna, WA	$357,348	Using a specific program of community-based activities to: o Establish community sports/fitness program; o Increase health and fitness awareness; o Increase access to physical activities; o Increase school children's access to balanced nutritional diet; o Increase nutritional awareness; o Decrease substance abuse; o Increase awareness of risk factors associated with chronic diseases; and o Increase collaboration between services and other organisations in the community.
Roebourne Primary School Parents and Citizen's Association	Roebourne, WA	$352,000	o To decrease the incidence of lifestyle related diseases (diabetes, obesity, heart disease).
The Shire of Upper Gascoyne	Gascoyne Junction, Woodgamia, Burringurrah and surrounding pastoral properties, WA	$358,866	o To enhance the health and lifestyle of the local people through the introduction of healthy lifestyles, social interaction and family orientated activities; o To reduce the incidence of chronic disease; o To decrease the incidence of alcohol and drug related injuries and illnesses; and o To develop an active and healthy lifestyle within the communities.
WA Country Health Services (Pilbara Gascoyne Population Health Unit)	Paraburdoo, Tom Price and surrounding Aboriginal Communities, WA	$276,100	o To reduce the proportion of people by 5% who are overweight or obese within the project area by 2007.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-115

OUTCOME 5: Rural Health

Topic: RURAL HEALTH STRATEGY – BUILDING HEALTHY COMMUNITIES IN REMOTE AUSTRALIA PROGRAM

Hansard Page: CA 124

Senator McLucas asked:

a) I am trying to work out how it would happen in a rural community. Does a person from Brisbane turn up and say, 'We think you are not very well, would you like some money? I am just trying to work out how it happens practically.
b) And that will explain to me how decisions between various communities are made?

Answer:

The Building Healthy Communities in remote Australia (BHC) Program targets the main risks for many preventable chronic diseases and injuries within communities. To qualify for funding, communities must have populations of less than 5,000 and be identified as having a high need and limited access to health services.

Previous experience in the Rural Chronic Disease Initiative, upon which the BHC program is based, showed that a competitive grant application process often put low capacity, high need communities at a disadvantage. Consequently a more targeted process was used for the BHC program.

Communities and potential auspice organisations were identified by the Department following extensive consultation with key stakeholders through the Department's State and Territory offices. Key stakeholders included Divisions of General Practice and health service providers such as Regional Health Services, the Royal Flying Doctor Service and State and Territory Government health departments.

Communities nominated for consideration as BHC projects were selected against the following criteria:

- an Accessibility/Remoteness Index of Australia (ARIA) classification of "remote" or "very remote";
- high needs of the community identified using the Socio-Economic Indexes for Areas and/or other appropriate locally conducted needs assessments;
- a high percentage of Indigenous people;
- a population of less than 5,000.

Other important elements or criteria for consideration included:

- unemployment rate within the community;
- health services available within the community;
- other services available within the community;
- evidence of poor health status;
- availability of infrastructure to support the project; and
- community interest and support.

Identified auspice organisations were invited to submit an expression of interest to participate in the program within those communities identified by the Department. These expressions of interest were considered by a Departmental Steering Group which recommended suitable projects for approval. The BHC Steering Group comprised officers from the Health Services Improvement Division, the Primary Care Division, and the Office for Aboriginal and Torres Strait Islander Health within the Department of Health and Ageing; and also representatives from relevant State and Territory Offices.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-117

OUTCOME 5: Rural Health

Topic: ROYAL FLYING DOCTOR SERVICE (RFDS)

Hansard Page: CA 117

Senator McLucas asked:

(a) Could you provide the Committee with the amount of funding provided to the RFDS by the Commonwealth over the last 5 years?

(b) The other issue is about what the other contributors; mainly the states are putting into the operations of the RFDS. Does the Commonwealth know the figure?

Answer:

(a) In the five years commencing 2001/02, the Department of Health and Ageing has provided $141,446, 000 to the RFDS. This includes expenditure to the end of February 2006.

(b) The Commonwealth is not aware of the contributions made by State and Territory Governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-127

OUTCOME 6: Hearing Services

Topic: HEARING SERVICES - HEARING SERVICES CONSULTATIVE COMMITTEE

Hansard Page: CA 87

Senator Crossin asked:

Perhaps you could give me all the names of the people on the Hearing Services Advisory Committee, or is it in the Hearing Services annual report?

Answer:

The names of the people on the Hearing Services Advisory Committee are:

Dr Robert Cowan
Mr Philip Davies
Ms Gayle Dicieri
Dr Harvey Dillon
Ms Anthea Green
Associate Professor Louise Hickson
Ms Helen King
Mr Barry MacKinnon
Mr Daniel McAullay
Ms Maureen McGrotty
Air V Marshall John Paule
Ms Jo Quayle
Mrs Margaret Robertson

Geographic Location of Eye Health Coordinators

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

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

Australian Government response to the review of the implementation of the National Aboriginal and Torres Strait Islander eye health program

http://www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pdf-govmay04-cnt.htm/$FILE/govmay04.pdf

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Revised Question: E05-061

OUTCOME 7: Indigenous Health

Topic: ANANGU-PITJANTATJARRA COAG TRIAL

Written Question on Notice

Senator Evans asked:

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

Answer:

The Department has provided input to the Office of Indigenous Policy Coordination (OIPC) on the AP Lands COAG trial in April 2005 and June 2004. These reports have not been released publicly as they are COAG documents and confidential to COAG. Any further questions in relation to these reports should be directed to the Department of Prime Minister and Cabinet.

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

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-025

OUTCOME 7: Indigenous Health

Topic: LINK UP PROGRAM

Written Question on Notice

Senator Siewert asked:

a) Can you report on the levels of funding and the ongoing commitment of funding to the Link Up program?
b) To what extent is the amount of funding allocated to this program responsive to demand for services?
c) How do you respond to the criticism that the level of funding for this program is inadequate and that case-loads on Link-Up workers are unmanageable and unsustainable – with some case workers reporting up to 88 clients (where 25 is considered a reasonable case-load)?
d) What training measures are in place for Link-Up workers to address the significant demands of the role?
e) What measures are in place to address the high levels of burn out and corresponding loss of experience and capacity with experienced and well-connected case-workers increasingly leaving the service?

Answer:

a) This year this Department allocated $4.157 million to the Link Up program ($3.824 million for recurrent activities plus $0.333 million for national activities).

Financial Year	**Funding Amount (GST excl)**
2004/05	4,016,000
2005/06	**4,157,000**
2006/07	4,278,000
2007/08	4,370,000
2008/09	4,462,000

b) The funding allocated to the Link Up program is historically based rather than demand driven. However, the level of demand will be considered as part of the evaluation of Link Up and related programs (see below).

c)

The Department has commenced a multi-program evaluation of the three related social health programs – Bringing Them Home; Social and Emotional Well Being and Mental Health; and Link Up.

The evaluation will:
- assess the impact of each program on its target client group(s);
- assess how effectively and efficiently each program is being delivered;
- identify strategies for strengthening coordination and collaboration among the services at local and regional levels, with a view to achieving more integrated, client-focussed services;
- develop recommendations to inform future program objectives, directions and alignment;
- identify best practice models and possible alternative service delivery models;
- assess Regional Centres' capacity to provide services across their state/territory and their locational and organisational arrangements; and
- develop recommendations to improve reporting and accountability.

An independent consultant has been engaged to conduct the evaluation. The multi-program evaluation is expected to be finalised by the end of September 2006.

d) Link Up workers are able to access the training and support offered by Social and Emotional Wellbeing Regional Centres, particularly in the area of grief, loss and trauma. Social and Emotional Wellbeing Regional Centres promote good practice, develop education packages and deliver mental health training for Indigenous health workers, provide clinical support (personal and professional) for Indigenous mental health workers, trial new ways of linking and working across sectors, and develop information systems to clarify the level of need in the region. The Social and Emotional Wellbeing Regional Centres are funded at the level of $5.568 million in 2005/06 through the Aboriginal and Torres Strait Islander Health appropriation.

The Department identifies and addresses other training needs such as:
- the Winangali Marumali Circle of Healing Model. The aim of the program is to increase the quality of support available to people affected by past practices regarding forced removal, through the provision of training and education based on the Winangali Marumali Circle of Healing. The Department provides funding to the program each year for a number of workshops to train Aboriginal health practitioners, including Link-Up case workers; and
- the Department is organising and funding training sessions in the use of Foxtrot and the National Names Index databases for Link Up Caseworkers. The databases are instrumental in the Link Up program's core functions of contact tracing and client record management; and
- the Department funds the Australian Institute of Aboriginal and Torres Strait Islander Studies (AIATSIS) to provide Family History Research training.

e) Funding provided by the Department for positions includes provision for transitioning, debriefing and succession planning. The multi-program evaluation will also address workforce issues. A National Link Up Forum is held each year to provide opportunities to discuss strategic issues, including workforce issues, needs and best practice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-073

OUTCOME 7: Indigenous Health

Topic: WORKPLAN FOR FUTURE ACTIONS IN EAR AND HEARING HEALTH

Hansard Page: CA 88

Senator Crossin asked:

a) Under 'monitor development of best practice in health promotion and facilitate dissemination of relevant information' it says that 'the department is exploring the use of health promotion officers within the communities'. Is there an update on that? Have you decided to put them there? To clarify that I just wanted to know where progress is on the use of health promotion officers within communities.

Answer:

a) The Department will not be establishing health promotion officer positions. However, the Department is pursuing other initiatives that will improve the skills base of Aboriginal and Torres Strait Islander Health Workers. For example, the new Aboriginal Health Worker and Torres Strait Islander Health Worker National Competencies and Qualifications to be introduced by June 2006 will include a specialist stream on ear and hearing health.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-095

OUTCOME 7: Indigenous Health

Topic: INDIGENOUS HEALTH WORKFORCE PROGRAM FUNDING

Hansard Page: CA 80

Senator Crossin asked:

My records tell me that I did not get the figure for 2004-05. Can you take that on notice?

Answer:

Allocation $9,312,904
Expended $8,950,053

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-096

OUTCOME 7: Indigenous Health

Topic: SOUTH AUSTRALIAN PROJECT ON IMPROVING UPTAKE OF THE OTITIS MEDIA GUIDELINES

Hansard Page: CA 82

Senator Crossin asked:

a) Has the Menzies School of Health Research got anything to do with that trial or project?

b) How long is this project for? Just a rough time frame will do, like whether it is one year or five years, I do not want an exact date.

Answer:

a) The Menzies School of Health Research is not directly involved in the implementation of the South Australian Otitis Media Clinical Support Systems project. However, the project maintains contact with Menzies as part of the Otitis Media Network of Australia.

b) The project is for approximately 18 months and is expected to be finalised by the end of the 2005-06 financial year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-097

OUTCOME 7: Indigenous Health

Topic: 2003 EYE HEALTH REVIEW

Hansard Page: CA 83

Senator Crossin asked:

Have I seen the outcomes of that review?

Answer:

Copies of the 2004 *Australian Government Response to the Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program* were tabled.

A copy of the 2003 *Review of the Implementation of the National Aboriginal and Torres Strait Islander Eye Health Program* is attached.

Note: the attachment has not been included in the electronic/printed volume but is accesible at this link
http://www.health.gov.au/internet/wcms/Publishing.nsf/Content//health-oatsih-pubs-eyehealth.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-098

OUTCOME 7: Indigenous Health

Topic: NATIONAL GUIDELINES FOR THE PUBLIC HEALTH MANAGEMENT OF TRACHOMA IN AUSTRALIA

Hansard Page: CA 91

Senator Crossin asked:

c) How big are the guidelines? Are they pages long?

Answer:

a) The Communicable Diseases Network Australia (CDNA) 'Guidelines for the public health management of trachoma in Australia' are sixty two pages long. The guidelines contain 29 recommendations on screening, treatment, data collection and reporting; and provide a minimum best practice approach. A copy of the published guidelines will be forwarded when printed.

The guidelines are available at this link:

http://www.health.gov.au/internet/wcms/publishing.nsf/content/F96420E57DD8A854CA257146007A9EC0/$File/Trachoma2.pdf

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-090

OUTCOME 8: Private Health

Topic: BRANCH CLOSURES – LAST 12 MONTHS

Hansard Page: CA 11

Senator McLucasasked:

Mr Savvides, how many branch closures have occurred in Medibank Private?

Answer:

Since 1 February 2005 two retail centres have been closed:

- University of NSW retail centre. Closed due to the site owner electing not to renew the lease.
- Eastwood retail centre. The decision to close this in-store kiosk was made due to the low level of usage by Medibank Private Limited members, the close proximity of alternative retail centres, security issues and potential Occupational Health and Safety risks.

In addition to the above there have been 14 relocations where one premises is closed and another opened in its place, generally within very close proximity to each other. Examples include:

- Relocation of Melbourne CBD locations (Centrepoint and Bourke Street) to the new Galleria shopping plaza.
- Tweed Heads retail centre relocated to nearby Elanora.
- Cairns, Launceston and Charlestown retail centres relocated locally.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-091

OUTCOME 8: Private Health

Topic: HOSPITAL PURCHASING SCHEME – MEMBER NOTIFICATION

Hansard Page: CA 10

Senator McLucasasked:

Do you understand that a lot of people from regional Queensland would go to John Flynn Hospital and would go for one event only, potentially? You probably did not write to people in Cairns?

Answer:

Medibank did not use geographic location when deciding which fund members should be contacted in regard to John Flynn Hospital losing Member's Choice status. Contact was based on past and future usage of the facility, with two groups of people identified.
The first group was people for whom Medibank records showed they had attended the hospital and made a claim between 1 July 2004 and 1 November 2005. The second group was a list provided by John Flynn Hospital showing Medibank member's who were pre-booked for procedures at the hospital or who had ongoing treatment for a chronic condition. A total of 3972 letters were sent to members to advise of the new contractual arrangements with John Flynn Hospital. Members from Cairns who met the above criteria were contacted. In addition to the above, Medibank and John Flynn Hospital jointly wrote to all doctors who had admitted a Medibank member to John Flynn Hospital in 2004, fully explaining how the new arrangements affect their patients and themselves.

Finally, during lead up to the Hospital Purchasing Scheme Medibank undertook an extensive nationwide newspaper advertising campaign, outlining and explaining the rationale for undertaking the scheme.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-092

OUTCOME 8: Private Health

Topic: HOSPITAL PURCHASING SCHEME – MEMBER COMPLAINTS

Hansard Page: CA 11

Senator McLucasasked:

What were the nature of the complaints?

Answer:

To date Medibank Private's Customer Resolution Team has received a total of 91 complaints in regard to the Hospital Purchasing Scheme (HPS) project. The complaints can be broken down into the following categories:

Complaint requiring further information on HPS such as process, outcome and alternatives	**36**
Complaint regarding out-of-pocket expenses	**23**
Request for special consideration	**3**
Complaint regarding restriction of choice	**8**
Non-specific HPS complaint concerning John Flynn Hospital	**4**
Non-specific HPS complaint concerning St. Vincent's hospital	**4**
Non-specific HPS complaint concerning Epworth Hospital	**13**
Total	**91**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-093

OUTCOME 8: Private Health

Topic: HOSPITAL PURCHASING SCHEME

Hansard Page: CA 9

Senator McLucasasked:

Could you provide the committee with a summary of these hospitals and where they are located by state?

Answer:

The following hospitals were included in Medibank's Hospital Purchasing Scheme Request for Proposal (RFP) process and as a result have received a Member's Choice contract:

Hospital Name	State
Strathfield Private Hospital	NSW
Castlecrag Private Hospital	NSW
Dalcross Private Hospital	NSW
Delmar Private Hospital	NSW
Holroyd Private Hospital	NSW
Hunters Hill Private Hospital	NSW
Calvary Health Care Sydney - Hurstville Community	NSW
Sydney Private Hospital	NSW
Mater Misericordiae Hospital	NSW
Eastern Suburbs Private Hospital	NSW
Sydney Adventist Hospital	NSW
Peninsula Private Hospital	NSW
Kareena Private Hospital	NSW
Nepean Private Hospital	NSW
Manly Waters Private Hospital	NSW
Macarthur Private Hospital	NSW
Canada Bay Private Hospital	NSW
President Private Hospital	NSW
The Hills Private Hospital	NSW
Sydney Southwest Private Hospital	NSW
Minchinbury Community Hospital	NSW
St Luke's Hospital Complex	NSW
St George Private Hospital	NSW
Hawkesbury District Health Service	NSW
Prince of Wales Private Hospital	NSW
North Shore Private Hospital	NSW

Alpha Westmead Private Hospital	NSW
Jessie McPherson Private Hospital	VIC
St John of God Health Care Berwick	VIC
Freemasons Hospital	VIC
The Bays Hospital Group Inc	VIC
Malvern Private Hospital	VIC
Cliveden Hill Private Hospital	VIC
St Vincent's & Mercy Hospitals (Mercy Campus)	VIC
Saint Frances Xavier Cabrini Hospital	VIC
John Fawkner - Moreland Private Hospital	VIC
Vaucluse Private Hospital	VIC
Mitcham Private Hospital	VIC
Cotham Private Hospital	VIC
Essendon Private Hospital	VIC
Beleura Private Hospital	VIC
Bellbird Private Hospital	VIC
South Eastern Private Hospital	VIC
St Vincent's & Mercy Hospitals (St Vincent's Campus)	VIC
Como Private Hospital	VIC
Mount Waverley Private Hospital	VIC
Masada Private Hospital	VIC
Linacre Private Hospital	VIC
Ringwood Private Hospital	VIC
The Avenue Hospital	VIC
Vimy House Private Hospital	VIC
Warringal Private Hospital	VIC
Peninsula Private Hospital *	VIC
Northpark Private Hospital	VIC
Mountain District Private Hospital	VIC
The Valley Private Hospital	VIC
Knox Private Hospital	VIC
Cabrini Brighton Private Hospital	VIC
Melbourne Private Hospital	VIC
Frances Perry Private Hospital	VIC
Western Private Hospital	VIC
La Trobe University Medical Centre	VIC
Glenferrie Private Hospital	VIC
Epworth Eastern Hospital	VIC
Brisbane Private Hospital	QLD
Mater Misericordiae Women's & Children's Private (Women's Campus & Children's Campus)	QLD
St Andrew's War Memorial Hospital	QLD
St Andrew's - Ipswich Private Hospital	QLD
Pindara Private Hospital	QLD
The Wesley Hospital	QLD
Sunnybank Private Hospital	QLD
Allamanda Private Hospital	QLD
The Peninsula Private Hospital	QLD
North West Brisbane Private Hospital	QLD
Mater Misericordiae Private Hospital	QLD
Greenslopes Private Hospital	QLD
Caboolture Private Hospital	QLD
Mater Misericordiae Hospital Redland	QLD
Pacific Private Hospital	QLD

Holy Spirit Northside	QLD
Ashford Hospital	SA
Blackwood & District Community Hospital	SA
The Burnside War Memorial Hospital Inc	SA
Calvary Healthcare Adelaide	SA
Glenelg Community Hospital Inc	SA
The Memorial Hospital Inc	SA
Parkwynd Private Hospital	SA
St Andrew's Hospital Inc	SA
Stirling & Districts Hospital	SA
Wakefield Hospital	SA
North Eastern Community Hospital Inc	SA
Western Hospital	SA
Central Districts Private Hospital	SA
Noarlunga Private Hospital	SA
Sportsmed - SA Hospital	SA
Flinders Private Hospital	SA

*Note: Peninsula Private was removed from the RFP process. This is due to Peninsula down grading its facilities and no longer fitting the appropriate profile. This has been approved by the probity auditor.

The following hospitals were included in the RFP and were awarded a Non-Member's Choice contract with Medibank:

Hospital Name	State
St Vincent's Private Hospital - Darlinghurst	NSW
Epworth Hospital	VIC
John Flynn - Gold Coast Private Hospital	QLD

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-056

OUTCOME 8: Private HealthTopic: BRANCH CLOSURES – LAST 12 MONTHS

Written questions on notice

Senator McLucasasked:

a) Can you outline how many branch closures have occurred in the last year?
b) How many of these have been re-locations?
c) How many of these are re-locations from shopping strips to shopping centres/malls?
d) Do you have any guidelines or geographical guides by which you base these office locations?
e) Is there any consideration given to locating with medical services - or is new customer interface the number one priority?
f) Can you outline why the office in Tweed Heads was moved across the border to The Pines shopping centre?
g) Isn't there already an office in Pacific Fair, located not too far away?
h) Doesn't this put elderly patients at a disadvantage?
i) Isn't this placing the membership drive before servicing existing customers?
Answer:

(a) & (b)

Since 1 February 2005, 16 branches have been closed. 14 of these branches have been relocations to a nearby location. Only 2 retail centres have been closed and not replaced with a nearby branch.

(c) Nil.

(d) Medibank Private Limited assesses each new site based on a variety of factors. These include but are not limited to market share, market potential, member penetration, distance from nearest location, Australian Bureau of Statistics data showing population growth trends and distribution, shopping centre refurbishments, available sites at the time, rent and other commercial considerations.

(e) In deciding Retail Centre locations Medibank considers multiple factors including the availability of complementing services. For example, one factor influencing the location of the Elanora retail centre at The Pines shopping centre was the operation of a Medicare office at the shopping centre.

(f) A review of Tweed Heads showed:

- Customer volumes at Tweed Heads were low and declining, particularly since the closure of the Medicare premises in the same shopping centre.
- On average Tweed Heads was processing 40-50% less than other retail centres.

A number of sites were considered for the new location before The Pines Shopping Centre at Elanora was settled upon. Factors in favour of Elanora included its proximity to major roads and transport links, and the location of a Medicare outlet at the shopping centre.

(g) There is an office located at Pacific Fair, 25 minutes away from Elanora. The estimated travel time from the old Tweed Heads Retail Centre to the new Elanora Retail Centre is 13 minutes.

(h) Medibank acknowledges that some members may be disadvantaged by the relocation of the Tweed Heads branch to Elanora. However, members who are not able to travel by car or public transport to the Elanora branch to conduct business in person may make use of the extensive telephone, post and internet facilities operated by the fund.

(i) Medibank tries to strike a balance between servicing the existing membership base and ensuring that it is attracting new members to the fund. In the case of the relocation of the Tweed Heads retail centre to Elanora, Medibank believes that the best decision has been made, as evidenced by the significantly higher customer visits at the new location compared to the former location at Tweed Heads.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

OUTCOME 8: Private Health
Topic: PRIVATE HEALTH INSURANCE

Hansard Page: CA 97

Senator Moore asked:

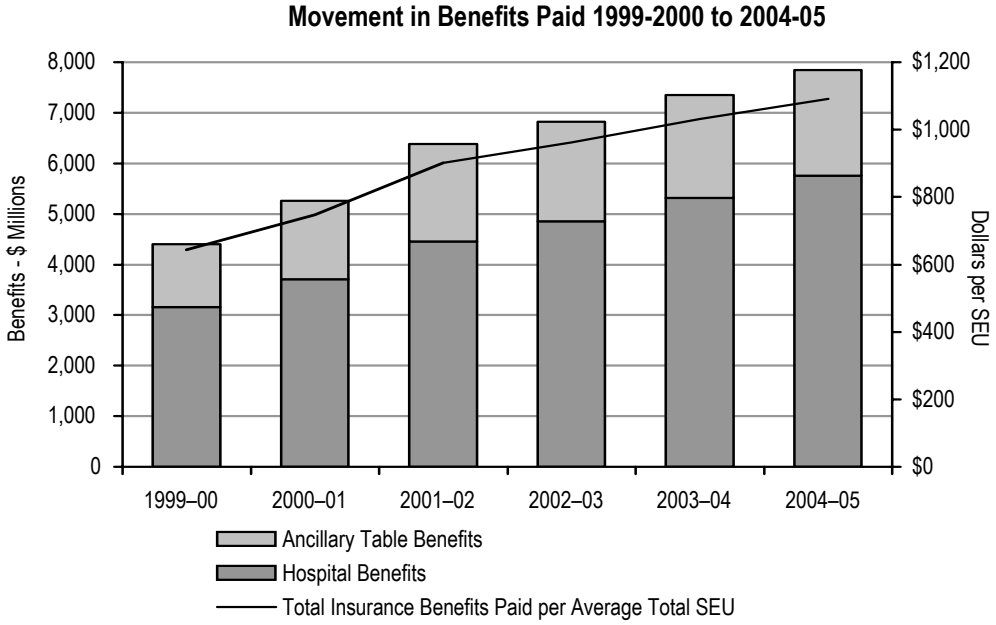
Is there increased utilisation both from the hospital visits and from the ancillary claims? Both those areas have grown?

Answer:
There has been a change in the proportions of hospital and ancillary benefits over recent years. Private Health Insurance Administration Council (PHIAC) data shows that during the introduction of Lifetime Health Cover (1999-2000) and for the year following its introduction (2000-01), there was a decrease in the level of hospital benefits as proportion of total benefits. Table 1 shows the benefits paid for hospital and ancillary benefits since 1999-2000.

Hospital and Ancillary Benefits Paid and Benefits Paid per Average SEU 1999-00 to 2004-05

	1999–00	2000–01	2001–02	2002–03	2003–04 r	2004–05
Hospital Table						
Benefits Paid ($'000)	3,162,708	3,712,935	4,459,243	4,854,359	5,319,014	5,751,278
% Change Benefits Paid	*3.2%*	*17.4%*	*20.1%*	*8.9%*	*9.6%*	*8.1%*
Benefits Paid per Average Hospital SEU	$693	$597	$715	$780	$854	$918
% Change Benefits Paid per Average Hospital SEU	*-5.8%*	*-13.8%*	*19.7%*	*9.1%*	*9.6%*	*7.5%*
Ancillary Table						
Benefits Paid ($'000)	1,242,834	1,543,482	1,921,476	1,968,551	2,034,867	2,092,155
% Change Benefits Paid	*8.7%*	*24.2%*	*24.5%*	*2.4%*	*3.4%*	*2.8%*
Benefits Paid per Average Total Ancillary SEU	$275	$281	$342	$342	$348	$351
% Change Benefits Paid per Average Total Ancillary SEU	*1.3%*	*2.3%*	*21.6%*	*0.0%*	*1.8%*	*1.0%*
Total Benefits						
Benefits Paid ($'000)	4,405,543	5,256,417	6,380,719	6,822,910	7,353,881	7,843,433
% Change Benefits Paid	*4.7%*	*19.3%*	*21.4%*	*6.9%*	*7.8%*	*6.7%*
Total Insurance Benefits Paid per Average Total SEU	$778	$747	$906	$964	$1,034	$1,092
% Change Benefits Paid per Average Total SEU	*-2.2%*	*-4.0%*	*21.3%*	*6.4%*	*7.3%*	*5.6%*

However since then most growth has been in hospital benefits. Ancillary benefits have decreased as a proportion of total benefits. The Graph below shows the relative proportions of hospital and ancillary benefits since 1999-2000.


Movement in Benefits Paid 1999-2000 to 2004-05
Benefits - $ Millions
Dollars per SEU
8,000
7,000
6,000
5,000
4,000
3,000
2,000
1,000
0
$1,200
$1,000
$800
$600
$400
$200
$0
1999–00
2000–01
2001–02
2002–03
2003–04
2004–05
Ancillary Table Benefits
Hospital Benefits
Total Insurance Benefits Paid per Average Total SEU

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Supplementary Budget Estimates 2005-2006, 2 November 2005

Question: E05-221

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES FOR MENTAL HEALTH INITIATIVE

Hansard Page: CA 50

Senator Moore asked:

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

Answer:

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

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

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

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

Financial year 2004-2005

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

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

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

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

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

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

NATIONAL CHRONIC DISEASE STRATEGY AND THE NATIONAL SERVICE IMPROVEMENT FRAMEWORKS

The National Chronic Disease Strategy (NCDS) and the National Service Improvement Frameworks (NSIFs) have been developed as a package under the auspices of the National Health Priority Action Council (NHPAC), a subcommittee of Australian Health Ministers Advisory Council.

The intent of the NCDS is to provide a consistent and coordinated approach to chronic disease prevention and management in Australia. The NSIFs are disease specific documents for major chronic diseases, complementing the overarching NCDS.

NSIFs have been developed for asthma; cancer' diabetes; osteoarthritis; rheumatoid arthritis and osteoporosis; and heat, stroke and vascular disease.

The National Chronic disease Strategy and associated documents were endorsed by the Australian Health Ministers Advisory Council on 20 October 2005. They were subsequently considered and endorsed by Australian Health Ministers on 18 November 2005.

The National Chronic Disease Strategy has been developed with input from clinicians, consumers and representatives of non government and Government organisations. Both the NCDS and the NSIFs were subject to extensive consultation through workshop and paper based consultations.

The National Chronic Disease Strategy has identified 41 key directions in the following action areas:

- Prevention;
- Early detection and early treatment;
- Integration and continuity of care; and
- Self management.

The National Service Improvement Frameworks

The NSIFs are high level "guides" to inform consumers; health service planners and designers, policy makers, managers, funders and providers about the most effective evidence based care.

Each NSIF describes key phases along the continuum of prevention and care and has developed critical intervention points to address current gaps in services. The key phases are:

- Reducing risk;
- Finding the condition early;
- Early stages;
- Acute episodes;
- Long term care; and
- Advanced stage/end of life.

NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL (NHMRC) ENDORSED GUIDELINES

Arthritis and Musculoskeletal

The Department of Health and Ageing has commissioned the Royal Australian College of General Practitioners to develop clinical guidelines for endorsement by NHMRC for:

- Osteoarthritis;
- Rheumatoid arthritis;
- Juvenile arthritis; and
- Osteoporosis.

Cancer

- Clinical Practice Guidelines: Non-melanoma skin cancer: Guidelines for treatment and management in Australia
- Clinical Practice Guidelines for the Management of Cutaneous Melanoma
- Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer
- Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer: A Guide for Patients, their Families and Friends
- Guidelines for the Prevention, Early Detection and Management of Colorectal Cancer: A Guide for General Practitioners
- Clinical Practice Guidelines for the Management of Early Breast Cancer
- Clinical Practice Guidelines for the Management of Advanced Breast Cancer
- Clinical practice guidelines for the management and support of younger women with breast cancer
- Psychosocial Clinical Practice Guidelines: Information, Support and Counselling for Women with Breast Cancer
- Screening for the prevention of cervical cancer: Guidelines for the management of women with screen detected abnormalities
- Screening to prevent cervical cancer: guidelines for the management of asymptomatic women with screen-detected abnormalities
- Clinical Practice Guidelines for the Management of Women with Epithelial Ovarian Cancer
- Clinical Practice Guidelines for the Prevention, Diagnosis and Management of Lung Cancer
- Clinical Practice Guidelines: Evidence-based Information and Recommendations for the Management of Localised Prostate Cancer
- Clinical Practice Guidelines: for the diagnosis and management of Lymphoma
- Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer
- Familial Aspects of Cancer: a Guide to Clinical Practice

Cardiovascular

- Clinical Guidelines for Stroke Rehabilitation and Recovery

Diabetes (Type 1 and Type 2)

- Australian Clinical Practice Guidelines for the Management of Type 1 Diabetes in Children and Adolescents
- Evidence Based Guidelines for Case Detection and Diagnosis of Type 2 Diabetes
- Evidence Based Guideline for Primary Prevention of Type 2 Diabetes
- Evidence Based Guideline for Blood Pressure Control in Type 2 Diabetes
- Evidence Based Guideline for Prevention and Detection of Macrovascular Disease in Type 2 Diabetes

- Evidence Based Guideline for Detection and Prevention of Diabetes Foot Problems
- Evidence Based Guideline for Lipid Control in Type 2 Diabetes
- Management of Diabetic Retinopathy: Clinical Practice Guidelines

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TABLE OF CONTENTS

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

Divisions of General Practice Funded to run Access to Allied Psychological Services	FUNDING for 2005-06, Including Expansion Funding
	GST Exclusive
ACT	
ACT Division of General Practice	320,076
	$ 320,076
NSW	
Bankstown	$ 119,797
Barrier	$ 97,200
Barwon	$ 100,408
Blue Mountains	$ 379,730
Canterbury	$ 90,000
Central Coast NSW	$ 480,231
Central Sydney	$ 381,881
Dubbo / Plains	$ 177,430
Eastern Sydney	$ 345,400
Fairfield	$ 211,200
Hastings Macleay NSW	$ 191,645
Hawkesbury Division (for Western Sydney)	$ 328,764
Hornsby Ku-ring-gai Ryde	$ 271,360
Hunter Rural	$ 137,192
Hunter Urban	$ 462,081
Illawarra	$ 257,616
Liverpool	$ 100,709
Macarthur	$ 231,584
Mid North Coast NSW	$ 196,228
Murrumbidgee	$ 266,653
Nepean & Hawkesbury	$ 383,027
New England	$ 126,811
North West Slopes	$ 117,052
Northern Rivers	$ 132,880
Northern Sydney	$ 184,161
NSW Central West	$ 472,495
NSW Outback	$ 90,000
Riverina	$ 299,765
Shoalhaven	$ 131,588
South East NSW	$ 162,046
Southern Highlands	$ 204,168
St George	$ 233,401
Sutherland	$ 193,152
	$ 7,557,656

NORTHERN TERRITORY		
Central Australia	$	66,000
Top End	$	370,781
	$	**436,781**

QUEENSLAND		
Brisbane North	$	548,951
Brisbane South	$	180,760
Cairns	$	102,235
Capricornia	$	125,329
Central Queensland Rural	$	158,784
Far North Queensland	$	168,584
Gold Coast & Tweed Valley	$	432,389
Ipswich and West Moreton	$	107,970
Logan Area - QLD	$	233,072
Mackay	$	186,255
North & West Queensland	$	241,380
Redcliffe Bribie Caboolture	$	83,298
South East Alliance (formerly Bayside Brisbane)	$	255,220
Southern Queensland Rural	$	343,323
Sunshine Coast	$	323,108
Toowoomba and District	$	292,151
Townsville	$	90,000
Wide Bay	$	226,025
	$	**4,098,833**

SOUTH AUSTRALIA		
Adelaide Central and Eastern	$	173,859
Adelaide Hills	$	120,605
Adelaide North East	$	210,136
Adelaide Northern	$	331,746
Adelaide Western	$	278,057
Barossa	$	99,000
Eyre Peninsula	$	121,500
Flinders and Far North	$	97,200
Limestone Coast	$	123,798
Mid North Rural SA	$	127,255
Murray Mallee	$	112,824
Riverland	$	169,621
Southern Division of Adelaide	$	291,288
Yorke Peninsula	$	120,999
	$	**2,377,889**

TASMANIA		
North West Tasmania	$	210,520
Northern Tasmania - GP North	$	201,047
Southern Tasmania	$	138,199
	$	**549,766**

VICTORIA		
Ballarat & District	$	167,586
Bendigo & District Div	$	281,884
Border	$	163,987
Central Bayside - VIC	$	139,278
Central Highlands - VIC	$	219,309
Central West Victoria	$	147,919
Dandenong Div	$	403,457
East Gippsland Div	$	372,980
Eastern Ranges GP Association	$	171,442
Geelong & Otway	$	374,139
Goulburn Valley	$	186,280
Knox - VIC	$	169,833
Mallee	$	185,176
Melbourne	$	262,271
Monash (Moorabbin)	$	182,840
Mornington Peninsular	$	256,753
Murray Plains	$	226,196
North East Valley - VIC	$	231,945
North East Victoria	$	252,771
North West Melbourne	$	285,815
Northern (VIC)	$	139,950
Southcity GP Services (Inner SE Melbourne)	$	203,279
Western Melbourne	$	207,760
Westgate	$	168,272
Whitehorse - VIC	$	392,233
	$	**5,793,355**

WESTERN AUSTRALIA		
Canning - WA	$	223,179
Central Wheatbelt	$	175,529
Eastern Goldfields	$	142,743
Fremantle Regional Div	$	287,196
GP Down South	$	212,725
Great Southern	$	130,383
Greater Bunbury WA	$	114,617
Mid West	$	134,951
Osborne	$	292,356
Perth & Hills WA	$	408,243
Perth Central Coast	$	122,870
Rockingham Kwinana	$	130,967
	$	**2,375,759**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-119

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES IN MENTAL HEALTH CARE

Hansard Page: CA 14-18

Senator Moore asked:

Question:

Does the Department have any data or information on:

(a) the number of patients who have identified with mental health issues who have not been able to access psychologists because of the six plus six limit?
(b) the cap on the number of referrals to psychologists, the possible impact of that and how that works across the whole scheme of mental health?
(c) the number of GPs registered with the program by RRMA?

Answer:

(a) No.

(b) The funding provided to Divisions of General Practice to operate an Access to Allied Psychological Services project is limited by the Budget allocation for the Program.

Funding is currently allocated to Divisions using the Outcomes Based Funding (OBF) formula. The OBF formula takes into account the population profile of each Division and is considered the most equitable way to distribute funding under the Better Outcomes in Mental Health Care Program.

The funding allocation limits the number of individuals who are able to be referred to allied health services through this Program. Better Outcomes funded allied health services is only one way allied health services are provided.

(c) The number of GPs registered with Medicare Australia to participate in the Better Outcomes in Mental Health Care Program by RRMA, up to 31 December 2005, is shown in the table below.

RRMA	Registered GPs who claimed a non referred attendance during previous 12 months (a)(b)
Capital City	2,774
Other Metro	345
Large Rural	430
Small Rural	421
Other Rural	831
Remote Centre	64
Other Remote	92
Australia	***4,399***

Based on Date of service, including data processed to the end of December 2005

(a)RRMA has been allocated based upon the GPs postcode where the service was provided.
Where a GP provided services in more than one RRMA, the GP is counted in each RRMA where the services were provided.

(b)GPs are counted only once in the national total. In the above table this means that the national total is less than the sum of the RRMA allocations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-120

OUTCOME 9: Health System Capacity and Quality

Topic: INTERACTION WITH MANLY WARRINGAH REGARDING BOIMHC PROGRAM

Hansard Page: CA 21

Senator Forshaw asked:

What interaction has the Department had with the Manly Warringah Division in relation to the Better Outcomes in Mental Health Care Program?

Answer:

The Department wrote to the Manly Warringah Division of General Practice in 2003-04 offering funding to auspice an Access to Allied Psychological Services (ATAPS) project under the Better Outcomes in Mental Health Care (BOIMHC) Program. The Department did not receive a response to this letter.

The Department wrote again to the Manly Warringah Division of General Practice in May 2005 inviting the Division to apply for funding. The Department did not receive a response.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-088

OUTCOME 9: Health System Capacity and Quality

Topic: E HEALTH

Hansard Page: CA 22

Senator McLucas asked:

Is the eligibility criteria for a Medicare smartcard, in the Tasmanian context, the same as for a Medicare card?

Answer:

The requirements are no different to the existing requirements for Medicare.

People eligible are permanent residents who are Australian citizens or who have a permanent resident visa.

Any Tasmanian who is Medicare eligible can request to either replace their old Medicare card or request the new Medicare smartcard.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-118

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES IN MENTAL HEALTH CARE (BOIMHC) EXPENDITURE

Hansard Page: CA 14

Senator Moore asked:

What is the up to date expenditure of all the elements (including Departmental/ DVA/Education and Training) of Better Outcomes in Mental Health Care (BOIMHC), including an indication of what is managed by the Mental Health and Suicide Prevention Branch?

Answer:

The total expenditure for all components of the Better Outcomes in Mental Health Care Program from commencement up to 31 December 2005 is $77,085,799.

The Mental Health and Suicide Prevention Branch manages the Access to Allied Psychological Services, Education and Training and GP Psych Support services components of the Better Outcomes in Mental Health Care Program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-124

OUTCOME 9: Health System Capacity and Quality

Topic: WORKFORCE ISSUES

Hansard Page: CA 25

Senator McLucas asked:

To start with, I go to the press release of Minister Abbott, dated 12 January, about workforce issues, and particularly to overseas trained doctors. The attachment to that media release identifies that 2,409 overseas trained doctors are working or about to start working in Australia. Can you give me a breakdown of how many of them are permanent Australian residents?

Answer:

The following is a breakdown of 2,409 overseas trained doctors who are working or about to start working in Australia as a result of the Strengthening Medicare measures:

- 2,126 are temporary resident doctors; and
- 283 are permanent resident doctors.

Of the 283 permanent resident doctors, 214 are GPs and 69 are specialists.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-128

OUTCOME 9: Health System Capacity and Quality

Topic: BETTER OUTCOMES IN MENTAL HEALTH CARE (BOIMHC)

Hansard Page: CA 21/22

Senator Allison asked:

Question:

The purpose of my question was to ask whether consideration had been given to alternatives to antidepressants for pregnant women. The answer was no, but I would like to ask again whether, since that time, there has been further consideration of this, whether the department regards this as a significant issue and whether, with developments in Better Outcomes, there is a need for us to focus on this particular issue?

Answer:

The National Prescribing Service (NPS) is funded by the Australian Government to improve Quality Use of Medicines. Managing depression was an NPS topic in late 2005 and therefore the focus of *NPS News 42* (October 2005) and *Prescribing Practice Review 32* (November 2005). *NPS News* is distributed to 55,000 health professionals and *Prescribing Practice Review* to approximately 18,000 GPs. The advice in these NPS materials is that management of depression is multifaceted with consideration of non-drug treatments a major option in the management plan. Non-drug therapy is advised first for treatment of mild depression.

As well as providing guidance on the use of anti-depressants when one is prescribed, the NPS materials cite the provisions under the Better Outcomes in Mental Health Care Program to support improved care. This program supports GPs in the management of their patients with a mental illness. GPs registered under the program have the option to refer these patients for a limited number of non-pharmacological therapies as part of their mental health care plan. In addition they can access advice from a psychiatrist within 24 hours from the GP Psych Support Service.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-087

OUTCOME 9: Health System Capacity and Quality

Topic: E HEALTH

Hansard Page: CA 29

Senator McLucas asked:

a) How many people are employed in NEHTA?
b) Are they directly employed or is it on a contractual basis?
c) Could you give me an indication of those people who are administrative and those people who have technical expertise?

Answer:

a, b and c)

As at 1 March 2006, National E-health Transition Authority (NEHTA) has a total of 39.6 FTE staff all of whom are on fixed term contract. Of those staff, 37.6 are technical staff and 2 are administrative staff.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-029

OUTCOME 10: Acute Care

Topic: AHMAC REVIEW OF NEWBORN SCREENING

Written Question on Notice

Senator Stott Despoja asked:

a) Given that the government stated in its response to "Essentially Yours: the Protection of Human Genetic Information in Australia" that it "supports the development of nationally consistent legislation and policies and practices governing the collection, storage, use and disclosure of, and access to, genetic information and samples on Guthrie Card", and that the Australian Health Ministers' Advisory Council's Advisory Group on Human Gene Patents and Genetic Testing is currently developing Principles and Guidelines for newborn screening, how is the government supporting the advisory group in its development of a nationally consistent approach?
b) At what stage is the Advisory Group in finalising the Principles and Guidelines for Newborn Screening? When will the Principles and Guidelines will be put to AHMAC for endorsement and public release?
c) Although the Advisory Group have conducted a targeted public consultation on the proposed Principles and Guidelines, will the wider community have an opportunity to provide feedback to AHMAC on them?
d) What follows this process? Do the Principles and Guidelines then go to the government?

Answer:

a) The Australian Government participates on and provides secretariat support to the Advisory Group.

b) The Advisory Group has considered the responses to the targeted consultation and is revising the draft Principles and Guidelines accordingly. Given the need to obtain expert advice across all jurisdictions, it is difficult to set a precise timeline for these events, but it is expected that the Principles and Guidelines will be put to AHMAC for consideration later this year.

c) Consultation on the draft Principles and Guidelines targeted key professional bodies and relevant stakeholders with an interest in newborn screening. The Advisory Group is not considering broader consultation at this stage.

d) It is not intended that the Principles and Guidelines will be formally considered by the Australian Government, because newborn bloodspot screening is the responsibility of the States and Territories. If endorsed by AHMAC, the guidelines would then be implemented by the States and Territories.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-089

OUTCOME 10: Acute Care

Topic: RADIOTHERAPY INTERNSHIP PLACES

Hansard Page: CA 102

Senator McLucas asked:

Do you have those places for the three elements of the program by state?

Answer:

State	**Radiation Therapy 2006 Professional Development Year Places (PDY)**	**Medical Physics Registrar/Trainees commencing 2006**	**Radiation Therapy Undergraduate places 2005**	**Radiation Therapy Undergraduate places 2006**
NSW	20	1	0	12
VIC	2	0	0	10
QLD	7	2	0	5
SA	5	1	5	5
WA	4	4	0	0
TAS	2	0	0	0
ACT	1	1	0	0
TOTAL	**41***	**9**	**5**	**32**

* The total has reduced since the initial response, as Victoria originally accepted 10 places, but has since reduced their request to 2 places.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-028

OUTCOME 11: Health and Medical Research

Topic: HUMAN GENETICS ADVISORY COMMITTEE (HGAC)

Written Question on Notice

Senator Stott Despoja asked:

(a) Has the Human Genetic Advisory Committee (HGAC) held its inaugural meeting?

(b) How often will the HGAC meet?

(c) Has the HGAC provided any advice to the government on issues associated with human genetics yet?

Answer:

(a) The Human Genetic Advisory Committee (HGAC) held its inaugural meeting on 16-17 February 2006.

(b) The HGAC plans to meet four times per year, with meetings of working groups as required. Information regarding the HGAC, including its meeting schedule can be found at http://www.nhmrc.gov.au/about/committees/hgac/index.htm

(c) The HGAC has not as yet provided advice to government.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-032

OUTCOME 11: Health and Medical Research

Topic: COLOUR BLINDNESS

Written Question on Notice

Senator Evans asked:

Can you inform the committee on the activities (if any) of the Department of Health and Ageing in dealing with colour blindness?

Answer:

The Department of Health and Ageing, through the National Health and Medical Research Council, has provided funding totalling $912,313 since the beginning of 2001 to projects for research into colour blindness led by Professor Paul Russell Martin (*Investigation of nerve signals in normal and abnormal colour vision*) and Dr Ulrike Gruenert (*Analysis of nerve cell connections in the eye*). Both research projects were funded through the University of Sydney.

In addition, the National Health and Medical Research Council is to provide funding totalling $581,250 over three years for a research project commencing in 2006 titled '*A study of brain pathways for colour vision*' led by Professor Paul Ronald Martin of the University of Melbourne.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-063

OUTCOME 11: Health and Medical Research

Topic: LOCKHART REVIEW COMMITTEE

Written Question on Notice

Senator Fielding asked:

a) Which area within the Department is considering the recommendations of the Lockhart Review Committee?

b) What is the process underway with states and territories to consider the recommendations of the Lockhart Review Committee leading up to its return to the Council of Australian Governments for decision?

c) Please provide details of the process and indicative timelines.

Answer:

a) The Acute Care Division of the Department of Health and Ageing, in consultation with the Office of the National Health and Medical Research Council, is contributing to the Australian Government's examination of the findings of the Lockhart Review.

b) On 10 February 2006, the Council of Australian Governments (COAG) agreed that Senior Officials would report on the independent review of the *Prohibition of Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002* at the next COAG meeting.

c) Senior Officials will report to COAG in mid 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-064

OUTCOME 11: Health and Medical Research

Topic: LICENSING COMMITTEE

Written Question on Notice

Senator Fielding asked:

a) The Licensing Committee has provided minutes of its meetings to the Community Affairs Committee. Please provide copies of minutes for any further meetings.
b) The minutes of the 31 August - 1 September 2006 meeting of the Licensing Committee noted a sub-committee of AHEC had been established to review the use of foetal tissue. Please provide details of the sub-committee's work.
c) The minutes of the 31 August - 1 September 2006 meeting of the Licensing Committee note AHEC's concerns about research governance and the role of HRECs. Please provide details of these concerns.
d) Please provide a copy of the "full report" the Chair provided on his visit to the UK's Human Fertilisation and Embryology Authority.
e) The minutes note a breach of section 24 by a licence holder. Please explain why the licence was not suspended, pending advice from the Director of Public Prosecutions.
f) Is recommendation 51 of the Lockhart Report, which advocates the Licensing Committee have the power to give binding rulings "not within the literal wording of the Act, or the regulations made under the Act", advocating that Parliament hand over policy making powers to the Licensing Committee?
g) Are there situations where the Licensing Committee believes such powers would be justified and in what circumstances?
h) Why should the committee be given the power to vary the decisions of Parliament?

Answer:

a) Minutes of the Licensing Committee meeting of 23-24 November 2005 are at Attachment A.

b) The *National Statement on Ethical Conduct in Research Involving Humans 1999* (the National Statement) is currently under review. NHMRC's document *Supplementary Note 5 – The Human Fetus and Use of Fetal Tissue* (NHMRC 1983) is also under review. It is anticipated that revised advice on the human fetus and the use of fetal tissue will be contained within the revised National Statement. The draft National Statement is currently undergoing a second round of consultation and Chapter 4 provides guidelines for the ethical conduct of research involving women who are pregnant, the human fetus *ex utero*, and human fetal tissue after the separation of the fetus from the woman.

c) AHEC is concerned to ensure that institutions which have a Human Research Ethics Committee (HREC) recognise and fulfil their responsibilities to adequately resource and maintain the HREC. Chapter 2 of the current National Statement details these responsibilities. The other key NHMRC document in the area of research governance is the Australian code for the responsible conduct of research, which is also currently undergoing a second round of community consultation.

d) A copy of the report is at Attachment B.

e) A report on the matter is included in the *NHMRC Licensing Committee Report to the Parliament of Australia* for the reporting period of 1 April 2005 to 30 September 2005. Suspension of the licence was not required as the licence holder voluntarily ceased activity on the licence pending the Licensing Committee's consideration of the issue.

f-h) The Australian Government will examine the findings of the Legislation Review Committee during 2006.

Australian Government
National Health and Medical Research Council

NHMRC LICENSING COMMITTEE

Endorsed Minutes of the Meeting of 23 – 24 November 2005
Menzies Room, The Chifley on Northbourne Ave, Canberra.

10.30am to 4.00pm Wednesday 23 November 2005; and

8.30am to 11.30am Thursday 24 November 2005

ATTENDANCE

Members:

Professor Jock Findlay (Chairperson)
Professor Don Chalmers (Deputy Chair)
Professor Bryan Campbell
Dr Graham Kay
Dr Helen Szoke (from 2pm 23 Nov)
Dr Julia Nicholls
A/Professor Christopher Newell

Secretariat:

Dr Clive Morris
Nigel Harding
Dr Mike Gear
Dr Alison Mackerras
Celia Jobson
Dr Harry Rothenfluh
Erica Sherburn
Julie Martin

Legal Services Branch:

Neil Dwyer

Observers:

Professor Peter Illingworth (Day 2, Agenda Item 11)

Item 1: Opening

The meeting commenced at 10.30am on Wednesday 23 November 2005.

Item 1.1: Apologies

There were no apologies for the meeting.

Item 1.2: Confidentiality and Conflict of Interest

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

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

Item 1.3: Confirmation of Agenda

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

Item 1.4: Chairman's Report

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

- the Endocrine Society of Australia (ESA) and the Society for Reproductive Biology (SRB) Annual Scientific Meeting at the Perth Convention Centre, WA from 4 – 7 September 2005;
- NHMRC Management Committee meetings in Canberra on 13 October and 17 November 2005; and
- a videoconference between the UK Human Fertilisation and Embryology Authority, NHMRC and Australian State and Territory regulatory bodies on 18 November 2005.

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

Item 1.5: Out of Session Activities

Members noted Out of Session activities and decisions made by the Committee since the 31 August – 1 September 2005 meeting, as presented in the meeting papers, including:

- member's endorsement of the Licensing Committee's section of the NHMRC Submission to the Legislation Review Committee, as discussed further under Agenda Item 9; and
- six licence variations as discussed under Items 6.2.4, 6.2.5 and 6.2.6.

Item 1.6: Committee Membership

Item 1.6.1: Committee Re-appointment

The Committee noted it will not be able to carry out its functions if the process for re-appointing members is not completed by the 31 December 2005.

The Committee noted that, in accordance with the new governance arrangements, members will be appointed to the Licensing Committee for the new triennium commencing on the 1 July 2006. These appointments will be in accordance with section 16 of the *Research Involving Human Embryos Act 2002.*

The Committee noted that the appointment of the Licensing Committee member who has membership in common with the Australian Health Ethics Committee (AHEC) cannot occur until the membership of AHEC for the new triennium has been confirmed.

Item 1.6.2: Committee Replacements (of resigned Members)

Members noted that the Minister is still working to appoint a replacement for Dr Megan Best who resigned in late 2004, and expressed its concern over the delay in the process. The Committee agreed that the work of the Committee was impeded by the current Membership vacancy of a person with expertise in research ethics.

Members noted the letter of resignation from Professor Peter Illingworth to the Minister on 30 September 2005, and noted his significant contribution to the Committee's work as the member with expertise in assisted reproductive technology.

Outcome: Members noted that the Secretariat will continue to work with the Minister to facilitate the appointment of Members to its two membership vacancies in a timely manner.

Action Arising: Chair to write to the Minister regarding Committee's concern over membership vacancies including timing of re-appointments.

Item 2: Minutes and Action Arising from Previous Meeting

The draft minutes of the 31 August - 1 September 2005 meeting were endorsed by members. The table detailing progress on Action Arising from the meeting of 31 August - 1 September 2005 was noted.

Item 3:NHMRC Activities

Item 3.1:Council Activities

Members noted the report provided by the Council Secretariat.

Item 3.2:Report by AHEC Representative

Professor Campbell provided a verbal report to inform members about matters considered by AHEC since the 31 August - 1 September 2005 meeting of the Licensing Committee.

Item 3.3: Interaction with GTRAP

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

Item 3.4: Secretariat Activities

Members noted the summary report on Secretariat staff movements and extended their appreciation to the two Secretariat members who have departed the secretariat team since the previous Licensing Committee meeting.

Item 3.5: NHMRC Governance Arrangements

Secretariat briefed the Committee on the known future governance arrangements of the NHMRC.

Item 4: Budget

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

Action Arising: Secretariat to progress agreed projects and report to the next Licensing Committee meeting scheduled for March 2006.

Item 5: Biannual Report to Parliament

Members were provided with a draft of the 6th Biannual Report to Parliament for the reporting period of 1 April 2005 – 30 September 2005 for discussion and endorsement.

Action Arising: Secretariat to publish the endorsed report after making agreed minor edits and submit to Parliament for tabling in December 2005. The Secretariat is to circulate printed publication to the Committee when available.

Item 6: Licence Considerations

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

Item 6.1: Applications

Members noted that since the 31 August - 1 September 2005 meeting of the NHMRC Licensing Committee there have been no new Licence Applications submitted and no Licence Applications are currently undergoing assessment.

Item 6.2: Variations

A possible conflict of interest was declared by Professor Campbell with respect to Agenda Items 6.2.2, 6.2.3, and 6.2.4. This was dealt with in accordance with NHMRC procedures.

Item 6.2.1: Summary of all Variations

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

Item 6.2.2: Proposed Variations to Standard Conditions

Members discussed the proposal to vary standard conditions 3001 and 5001 to clarify the requirements for licence holders.

Decision:
Members agreed to the proposed wording for the two conditions and instructed the Secretariat to advise licence holders of the intended variations and then to vary the Licence conditions in accordance with established procedures.

Item 6.2.3: Variations to Licence 309701, 309702A and 309702B.

Secretariat informed members of action taken with respect to this variation since the previous meeting. Members noted that Secretariat had not received a response to its letter, dated 31 October 2005, and that further action was dependent on the licence holder's response.

Outcome: No decision.

Action Arising: Waiting for Licence Holder response

Item 6.2.4: Application to Vary Licence 309703

Secretariat informed members of the results of the out-of-session process to decide this application to vary Licence 309703. Since a quorum had not been reached, the request for a decision was repeated to the Committee. Members agreed to permit the thawing of all embryos specifically for Licence 309703 to allow three variations to the License, which are:

- allowing the authorised activity to be conducted at an additional site;
- approving a minor change to the consent documents for the project; and
- removing the requirement for 35 embryos to be used under Licence 309701 before being allowed to be used under Licence 309703.

Members also agreed to reduce the number of embryos that could be thawed specifically for Licence 309702B so that there was no change to the total number of embryos authorised for use in the linked licences. Members agreed to vary Licence 309701, to reflect the changes to Licences 309702B and 309703. Members agreed that the variations were consistent with the requirements of s.21(4)(a) of the RIHEA.

Decision: Members agreed to approve the application to vary Licence 309703. Members decided to approve the variations to Licence 309701 and Licence 309702B which required to give effect to the variation to Licence 309703.

Item 6.2.5: Application to Vary Licence 309707 – Use of Blastomeres to derive ESCs

Members considered a request from the Licence Holder to permit embryos authorised for use under Licence 309707 to be biopsied, to remove one or two cells at an early stage of development. These cells would be cultured in an attempt to

establish embryonic stem cell lines. The embryos would continue in culture to the morula or blastocyst stages of development, and then destroyed to obtain cells that would be cultured to obtain additional cell lines.

Members approved the application to vary the licence for the following reasons:

- the variation may enable achieving the goal of 20 embryonic stem cell lines while using fewer embryos, which is consistent with the requirements of s.21(4)(a) of the RIHEA;
- the establishment of embryonic stem cell lines from single blastomeres without destroying embryos would be a significant scientific advance; and
- embryonic stem cell lines obtained from single blastomeres could also be used to give rise to placental cells.

Members emphasised that the total number of embryonic stem cell lines (20 lines) permitted to be established under this licence has not changed.

Decision: Members agreed to vary Licence 309707 to permit the use of blastomeres to derive embryonic stem cell lines.

Action Arising: Secretariat to finalise the variation.

Item 6.2.6: Variation of Licence 309707 in response Licence Holder Non-compliance

At the previous meeting, members agreed to vary Licence 309707 in response to the non-compliance reported to that meeting. The variation includes a new condition (Condition 9107) and revised wording to clarify condition 9106.

Members noted that the proposed wording had been second-counselled and agreed that the licence should be varied as proposed.

Members also:

- acknowledged the findings of the Commonwealth Director of Public Prosecutions and the completion of the investigation;
- noted the follow-up actions of the Secretariat;
- noted the satisfactory outcome of the monitoring inspection conducted on 4 October 2005 (see Items 7.3 and 7.4);
- noted that the proposed change to Standard Condition 5001 (Item 6.2.2) was intended to improve clarity for licence holders and to help prevent similar non-compliances in the future; and
- noted the efforts of the licence holder to ensure that all persons involved are aware of their responsibilities and the administrative procedures developed to prevent any recurrence.

Decision: Members agreed to vary Licence 309707 to include the additional and revised conditions.

Action Arising: Secretariat to finalise the variation.

Item 6.3: Consent

Item 6.3.1 – Consent Advice received to date

Members noted the information provided.

Item 6.3.2 – Consent Checklist

Members noted the concerns of the Executive Director but stated that the HREC members who participated in the AHEC workshop in May had found the checklist very helpful.

Decision: Members agreed that the checklist would benefit from some editing to improve clarity and that this could occur in connection with the revision of the Information Kit (see Item 12.5)

Action Arising: Secretariat to progress this item

Item 6.3.3 – Rescind LC/ AHEC joint advice

The Committee agreed that the documents "Advice from the Australian Health Ethics Committee and the Licensing Committee of the NHMRC on the legislative requirements for obtaining proper consent for research on excess ART embryos" and "Obtaining consent: Stages where declarations or consent forms are required" have been superseded by the "Ethical Guidelines on the use of Assisted Reproductive Technology in clinical practice and research" (2004) (the ART guidelines 2004). The two advice documents can be rescinded, since the ART guidelines 2004 have been prescribed by regulation for the purposes of the RIHEA.

Decision: Members agreed to rescind the "Advice from the Australian Health Ethics Committee and the Licensing Committee of the NHMRC on the legislative requirements for obtaining proper consent for research on excess ART embryos" and "Obtaining consent: Stages where declarations or consent forms are required".

Action Arising: Secretariat to arrange for the website to reflect this decision.

Item 7: Compliance and Assessment

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

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

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

Item 7.2: Report on Records Audit Inspections

Members noted that no Records Audit Inspections had been conducted since the last Licensing Committee meeting of 31 August - 1 September 2005.

Item 7.3: Report on Monitoring Inspections

Members noted that one Monitoring Inspection had been conducted since the 31 August - 1 September 2005 meeting.

Decision: The Committee was satisfied with the outcomes.

Action Arising: A summary of the Monitoring Inspection to be included in the next Licensing Committee Report to Parliament for the period 1 October 2005 to 31 March 2006.

Item 7.4: Investigation in Licence 309707 - Update

Members noted that the investigation is now closed and that administrative actions by the Licensing Committee, including varying the licence to add a new special condition in order to further clarify the licence holder's responsibilities in relation to reporting to the Committee, are being progressed by the Secretariat.

Outcome: The Committee noted the information provided.

Action Arising: A summary of the Monitoring Inspection to be included in the next Licensing Committee Report to Parliament for the period 1 April 2005 to 30 September 2005.

Item 7.5: Licence Holder Biannual Reports

Members noted that all Licence Holders had provided reports on the use of excess ART embryos for the reporting period of 1 April to 30 September 2005.

Item 7.5.1: Summary of Excess ART embryo usage

Members noted the information provided and requested additional information be included in future versions of the summary table. Members requested licence holders be notified that the Committee expects the reports to include information to demonstrate whether any human embryonic stem cell lines meet the Committee's criteria.

Action Arising: Secretariat to write to relevant licence holders.

Item 7.5.2: Report of Licence 309700

Members noted the information provided.

Item 7.5.3: Report of Licence 309701 - 309703

Members noted the information provided.

Item 7.5.4: Report of Licence 309704

Members noted the information provided.

Item 7.5.5: Report of Licence 309707

Members noted the information provided.

Item 7.5.6: Report of Licence 309708

Members noted the information provided.

Item 7.5.7: Report of Licence 309709

Members noted the information provided.

Item 8: Biological Definition of Human Embryo

Members noted the project was completed and would be presented to the NHMRC Council at the next meeting to be held 8-9 December 2005.

Action Arising: Secretariat to keep Members informed of the progress of the project.

Item 9: Review of Legislation

Members noted the information provided and requested that the report from the Lockhart Committee be provided to members when it is tabled in Parliament.

Action Arising: Secretariat to distribute the outcome report from the Lockhart Review Committee when available during December 2005.

Item 10: Database Project

Members noted the progress of the Database project.

Item 11: Use of Excess ART Embryos created recently in Licensed Activities

Members agreed further discussion including consultation with AHEC was necessary.

Action Arising: Secretariat to organise a joint meeting between Licensing Committee and AHEC to discuss this issue as soon as possible in 2006. Members requested:

- a description of typical IVF cycles with PGD be circulated to all Licensing Committee and AHEC members; and
- scientific justification for using fresh rather than frozen embryos and legal advice on declaring embryos excess before embryos are created or identified as affected by a genetic condition.

Item 12: Communications Activities

Item 12.1: Information Exchange Visits (IEVs)

Members noted the report on the Information Exchange Visit (IEV) to IVF Friends, Victoria on 27 October 2005. Members discussed options to improve IEV's in order to improve communications with consumers.

Outcome: The Committee noted responses were pending from several organisations regarding Information Exchange Visits.

Item 12.2: Communications working group update

Members discussed options to improve overall communications with the Australian community and stakeholders.

Action Arising: Secretariat to progress communications strategy with Licensing Committee Communications Working Group prior to the next meeting with the NHMRC Information Communications Unit.

Item 12.3: Consumer health update

Members noted that, by invitation, Dr Julia Nicholls is writing a paper for Consumer Health Forum.

Item 12.4: Information Bulletin & Targeted Information Sheet

Members noted that the 3rd Information Bulletin will be distributed to consumer groups by Secretariat in December 2005.

Action Arising: Secretariat to finalise printing and distribute to consumer groups and members.

Members noted the status of the targeted information sheets.

Action Arising: Secretariat to progress the publication process of the targeted information sheets, and on members request, include counsellors within IVF Clinics in the distribution list.

Item 12.5: Information Kit

Members noted the comments from the Executive Director and agreed to the proposed outline for the revised information kit. Members agreed that a technical writer could be engaged to progress this activity, and a decision was made that one would be engaged by the Secretariat.

Item 12.6: Stakeholder feedback on communication activities

Members noted the information provided.

Item 13: HFEA videoconference and information exchange

Members noted the information provided.

Item 14: Meeting Dates 2006

Item 14.1: Licensing Committee Meeting dates for 2006

Members noted the proposed dates for Licensing Committee meetings for 2006.

Action arising: Members noted the proposed meeting dates would be rescheduled and circulated by Secretariat for agreement by Members Out-Of-Session.

Item 15: Other Business

Item 15.1: Update - Adoption of 2004 ART Guidelines in Regulations

Members noted that the inclusion of the 2004 ART Guidelines in the Regulations has been finalised.

Item 15.2: Update - National Application Form

The Committee noted progress on the National Application Form.

Action Arising: AHEC Secretariat to progress staged web-based roll-out of the form prior to the end of 2005.

Item 15: Conclusion of Meeting

The meeting concluded at 11:30am on Thursday 24 November 2005.

MEETING WITH THE HUMAN FERTILISATION AND EMBRYOLOGY AUTHORITY (HFEA)

HFEA licences - Licence Committees

- The HFEA issues licences for assisted reproductive technology treatment centres (eg IVF clinics), licences for human embryo storage centres that do not conduct clinical treatment and licences for embryo research.
- Licence applications are decided by a total of 3 Licence Committees:
  - 2 Licence Committees to decide treatment and storage licence applications;
  - 1 Licence Committee to decide research licence applications.
- The treatment and storage Licence Committees meet fortnightly while the research Licence Committee meets monthly.

HFEA research licences - application processing information

- The research licensing process is as follows:
  1. Applications are accepted only if approved by a local Ethics Committee.
  2. The HFEA Research Department licensing staff check the application for completeness, prepare a lay title & lay summary which is made publicly available on www.hfea.gov.uk.
  3. The application is sent to 2-3 external peer reviewers, who are experts in the field. These peer reviewers make a recommendation as to whether the application should be accepted as is, accepted with amendments or rejected. The peer review is de-identified and sent to the applicant for comment and/or providing requested amendments. In the past year only one application has been rejected outright. Due to potential conflicts of interest the HFEA anticipates recruiting peer reviewers from overseas in the near future.
  4. While the peer review process is progressing, HFEA inspectors and an external adviser conduct an inspection of the laboratory. The external advisor is not necessarily an expert in the specific research area but someone who can assess the following:
     - security provisions for the facility;
     - equipment required for the conduct of the proposed research is available;
     - consent process;
     - processes for handling patient information; and
     - experience and qualifications of the counsellors and researchers.
  5. The HFEA seeks submissions from the public on the application.
  6. The HFEA provides the following to the Research Licence Committee:
     - complete application;
     - Ethics Committee assessment;
     - peer review comments;
     - inspection report;

        - licensing history of applicant; and
        - public submissions.
    7. The Research Licence Committee decides whether a licence should be issued.

- The HFEA aims to have each research licence application placed on the Research Licence Committee agenda approximately 4 months after receipt of the application.
- Research Licences are issued for a maximum of 3 years for licence renewals or for research that does not involve new techniques.
- For novel research, first-time applicants or newly established research organisations licences are issued for a maximum of 1 year.
- As at 17 June 2005 there were:
    - 32 current research licences;
    - 6 applications for new research projects; and
    - 2 renewal applications for existing licences.
- The HFEA has amended its procedures to include the publication of lay summaries of research licence applications and of licences that have been issued on their internet site.

HFEA research licences - consent information

- In the UK researchers have the following options for research involving human embryos:
    - creating embryos for research;
    - using somatic cell nuclear transfer or parthenogenesis to create human embryos for research;
    - using cryopreserved embryos; or
    - using embryos that have not been cryopreserved.
- The majority of human embryos used in licensed research are non-cryopreserved embryos.
- Patients are usually given treatment information and research information at the same time and by the same person, usually a counsellor.
- Patients indicate **before** treatment starts whether their excess embryos are to be allowed to succumb, donated to another couple or donated to research.
- The person who decides which embryos will be implanted should not be involved in the licensed research activity.
- Patients who have cryopreserved embryos they wish to donate to research are usually given declaration of excess documents and specific consent documents at the same time.

HFEA research licences - monitoring & compliance information

- The HFEA prepares 6 monthly monitoring plans and gives licence holders notice when the plan is completed.
- Each monitoring inspection is conducted by 3-4 HFEA inspectors and an external adviser who is an expert in a relevant research area. HFEA inspectors have a background in a relevant area of science or a background in law.
- HFEA conducts unannounced inspections of treatment licence holders but does not conduct unannounced inspections of research licence holders.
- Monitoring inspections are conducted annually, unless compliance issues require additional inspections.
- Monitoring inspections take approximately 2 - 5 hours.
- Approximately 15 embryos are tracked from consent to research outcomes during each monitoring inspection, depending on the complexity of the licensed activity.
- HFEA inspectors pay particular attention to criteria used to determine which of the non-implanted embryos will be cryopreserved.
- HFEA inspectors have powers to apply for entry and seizure warrants but are required to execute any warrant in the presence of a police constable. Any evidence discovered during the execution of a warrant would be seized by the police.
- HFEA inspectors have been refused entry by a treatment licence holder on one occasion. HFEA inspectors subsequently applied for an entry warrant. Although they were not issued with the warrant, the fact that the application was made resulted in the licence holder allowing HFEA inspectors to conduct the inspection.
- If a minor non-compliance is detected during an inspection HFEA inspectors report to the Research Licence Committee who will take appropriate action.
- If a serious non-compliance is detected during an inspection the HFEA inspectors will:
    - immediately contact HFEA lawyers for advice;
    - convene a Research Licence Committee meeting (probably via teleconference) to suspend the licence immediately or as soon as a quorum of Committee members are available; and
    - apply for a warrant and contact police for execution of the warrant.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-074

OUTCOME 12: Biosecurity and Emergency Response

Topic: CREATION OF THE OFFICE OF HEALTH PROTECTION

Senator McLucas asked:

So 79 existing staff and the rest new?

Answer:

There were 79.7 full time equivalent staff positions in the former Biosecurity and Disease Control Branch. These positions formed the basis of the Office of Health Protection as at 1 January 2006. It is envisaged that there will be 150 full time equivalent staff positions in the Office of Health Protection by 30 June 2006.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2005-2006, 16 February 2006

Question: E06-075

OUTCOME 12: Biosecurity and Emergency Response

Topic: FUNDS TO ASPREN

Senator McLucas asked:

I do not think I have a breakdown of the $6.5 million for the strengthening of Australia's influenza networks, on notice could you provide a breakdown of that?

Answer:

The $6.5 million over five years for the expansion and strengthening of Australia's influenza surveillance networks provides $4.51 million to build and maintain an Information Communication Technology system, called the Syndromic Surveillance System (SSS), that supports the expansion of information exchange on influenza-like illnesses from Emergency Departments, sentinel GPs, and sentinel hospitals to the Department of Health and Ageing; $1.98 million in associated staffing, and $.07 million to establish and strengthen the National Influenza Co-ordinator Network consisting of representatives of the influenza surveillance community.

As part of the $4.51 million to build and maintain the SSS, the Department of Health and Ageing will invest resources to work collaboratively with the Australian Sentinel Practice Research Network (ASPREN) to update their influenza reporting system to feed directly to the SSS. It is expected that this investment will be in the order of $100,000.