Community Affairs
Legislation Committee

Examination of Budget Estimates 2000-2001

Additional Information Received
VOLUME 5
Outcomes 1 – 5, 7 – 9
HEALTH AND AGED CARE PORTFOLIO

FEBRUARY 2001

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. The title page of each report has been included in this document for reference purposes.

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2000-2001

Included in this volume are answers to written and oral questions taken on notice relating to the supplementary estimates hearing on 22 November 2000

HEALTH AND AGED CARE PORTFOLIO

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

WHOLE OF PORTFOLIO **Question: E027**

Topic: GST

Written Question on Notice

Senator Evans asked:

> **Has the Department undertaken any study of the costs of the implementation of the GST on public hospitals? How great have these administrative costs been?**

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2000-2001 22 November 2000

PORTFOLIO LEADERSHIP **Question: E028**

Topic: GST

Written question on notice

Senator Evans asked:

What is the basis the Department intend using to calculate the WC11 index for 2000/2001 removing the inflation spike produced by the GST in the current six months?

Answer:

WCI-1 is a weighted index constructed by the Department of Finance and Administration that measures changes in wage and non-wage costs. The non-wage component of the index is based on Treasury estimates of the CPI excluding the impact of the introduction of The New Tax System (TNTS) on the CPI. The ongoing CPI estimate (excluding the estimated impact of TNTS) will be used for indexation purposes for most Commonwealth expenses. Since Government agencies effectively pay no GST because they can claim input tax credits for GST on their purchases, there is no need to increase funding by the GST factor in the CPI to maintain real buying power.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

WHOLE OF PORTFOLIO **Question: E030**

Topic: GST

Written question on notice

Senator Evans asked:

(a) Why does the Government consider an injection for varilrix (chickenpox) to be the equivalent to cosmetic surgery and therefore not exempt from the GST?

(b) How is this medical service different from other health prevention procedures and why should it be subject to the GST?

Answer:

The Government does not consider varilrix vaccinations to be equivalent to cosmetic surgery.

Varilrix vaccinations are GST-free 'medical services' for the consumer under section 38-7 of the A New Tax System (Goods and Services Tax) Act 1999, which provides for GST-free status, where either:

(a) a medicare benefit is payable; or

(b) the vaccination is supplied by or on behalf of a medical practitioner, is generally accepted in the medical profession as being necessary for the appropriate treatment of the recipient of the supply.

'Appropriate treatment' includes the principles of preventative medicine.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

WHOLE OF PORTFOLIO **Question: E031**

Topic: GST

Written question on notice

Senator Evans asked:

The Departments response to Question 210 asked by Senator Evans on 22 May 2000 regarding the application of the GST and professional health services states:
The current list of professions approved to provide GST-free services is being monitored having regard to information provided by the professions and the policy objective of limiting inclusion to those professions who provide commonly used services, are recognised under State and Territory law, or whose members are covered by a national body with uniform national registration requirements.

(a) Has the Department received requests for lactation consultants' services to be exempted from the GST?

(b) What consideration is being or has been given to include all lactation consultants on the list of approved GST-free services?

(c) Why aren't the services of these practitioners recognised to be GST-free?

Answer:

(a) The Department has received requests for lactation consultants' services to be exempted from the GST.

(b) This proposal has been considered, but it has been decided not to recommend the inclusion of lactation consultants on the list of approved GST-free services.

(c) The list of GST-free 'other health services' was originally outlined in the Government's policy document: *Tax Reform: not a new tax, a new tax system*. The Tax Consultative Committee, established by the Government in 1998 to consider the scope of GST-free areas, extended the list to include services of a similar nature to those originally identified.

The list of GST-free'Other health services' was intended to encompass a range of mainstream, commonly-used and established allied health services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

WHOLE OF PORTFOLIO **Question: E045**

Topic: AGREEMENTS BETWEEN STATES AND COMMONWEALTH

Written Question on Notice

Senator Evans asked:

Can the Department please list:

(a) Multilateral agreements between States and Commonwealth combined

(b) Bilateral agreements to which all States have signed an agreement on that subject with the Commonwealth

(c) Bilateral agreements involving one or more States with the Commonwealth on issues of mutual interests.

Answer

(a)

- MOU between the Commonwealth and the states and territories and the Australian Red Cross Blood Service in relation to the establishment of a National Managed Fund to provide Blood and Blood Products liability cover for Australian Red Cross Blood Service 1 June 2000.

- State of Victoria and the Southern Health Care Network for Coordinated Care Trial (CCT)
- State of Victoria and North Western Health Care Network for CCT
- State of Queensland and TEAMCare Health Pty Ltd for CCT
- State of South Australia for Healthplus CCT
- State of South Australia for Care 21 CCT
- State of South Australia for development of detailed design proposal for 2nd round CCT
- State of New South Wales and Northern Sydney Area Health Service for CCT
- State of New South Wales and the Illawarra Area Health Service for CCT
- State of Tasmania for Careworks CCT
- Australian Capital Territory and the ACT Division of General Practice for CCT

- Commonwealth, State, Territory Strategy on Healthy Ageing – multilateral agreement between States and Commonwealth combined.

- A 5 year (1996-97 to 2000-01) multilateral Memorandum of Understanding signed by all States and Territories to establish a National Public Health Partnership (NPHP).

  The Food Regulation Agreement 2000 between the Commonwealth of Australia and the States and Territories which establishes a new framework for a co-operative national food regulatory system and provides a new mechanism for the development and adoption of food standards.

- Agreement between Commonwealth of Australia and the States and Territories of Australia and the Australian Institute of Health and Welfare concerning the provision of data on welfare services.

(b)

- MOU between the Commonwealth and the States and Territories regarding a cost shared funding arrangement to provide financial assistance to Australians Donate, Australian Donor Awareness Program for Transplantation (ADAPT) and the registries.

  Each jurisdiction signed a separate (mirrored) MOU:

- Innovative health services for homeless youth is a bilateral agreement between the Commonwealth and each of the States and Territories

- The Commonwealth provides annual funding to each State and Territory governments to manage and administer the Aged Care Assessment Program

- The Commonwealth has bilateral agreements with each State/Territory for the delivery of Home and Community Care Services

- Public Health Outcome Funding Agreements.

- Hepatitis C Education and Prevention Initiative

- Council of Australian Governments Illicit Drug Diversion Package, including Supporting Measures Relating to Needle and Syringe Programs

- Australian Health Care Agreements

- Memorandum of Understanding between the Commonwealth of Australia and the Government of the Northern Territory for the Supply of Pharmaceutical Benefits Scheme medicines to Territory operated and/or funded remote area Aboriginal health services under the provisions of section 100 of the *National Health Act 1953*.

- Strengthening Support for Women with Breast Cancer

- Agreements on Aboriginal and Torres Strait Islander Health

- The National Indigenous Pneumococcal and Influenza Immunisation Program.

(c)

- The Commonwealth provides funding to State governments to manage and administer the Dementia Support for Assessment Program.

- The Commonwealth provides funding to all States and the Northern Territory government to manage and administer the Psychogeriatric Care Units Program.

- Under the Non-Government Organisation Treatment Grants Program the Commonwealth has a Deed of Agreement with New South Wales for the purpose of administering grant funds to approved grant services in New South Wales.

- Bilateral agreements for the provision of human quarantine services.

- Agreement between the Commonwealth of Australia and the State of South Australia for the Administration and Management of the Hospital at Woomera.

- Agreement with Queensland for the employment of a diabetes medical specialist in the Torres Strait Islands.

- Northern Territory and Katherine West Health Board for the extension and transition phase of the Coordinated Care Trial.

- Northern Territory and Tiwi Health Board for the extension and transition phase of the Coordinated Care Trial.

- Western Australia and Derbal Yerrigan for the extension and transition phase of the Coordinated Care Trial.

- New South Wales and Maari Ma for the extension and transition phase of the Coordinated Care Trial.

- Northern Territory for the Remote Communities Initiative in Central Australia.

- Queensland and Northern Peninsula Area Women's Shelter for the Remote Communities Initiative.

- Queensland and Karboyick Larkinjar Aboriginal Corporation for Health and the Remote Communities Initiative.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

WHOLE OF PORTFOLIO **Question: E046**

Topic: INTERNATIONAL HEALTH ACTIVITIES

Written Question On Notice

Senator Evans asked:

Can the Department please list

(a) All projects in overseas countries to which the Commonwealth Government is a financial contributor?

(b) All activities involving overseas travel involving the Department of Health and Aged Care?

(c) All meetings and conferences of the World Health Organisation or other United Nations health committees to which Australia made input?

Answer:

(a) The majority of Australian government funding for health related activities in overseas countries is provided by AusAID. The Department of Health and Aged Care works closely with AusAID on a number of projects.

However, during the 1999/2000 financial year, the Department of Health and Aged Care supported research projects in Russia, under the Australia/Russia Agreement on Co-operation in the Field of Medical Science and Public Health.

(b) Activities involving overseas travel by departmental officers included:

- participation in international symposia, working groups and conferences on health policy and technical health matters;
- undertake fellowships or secondments with organisations;
- provision of advice to health ministries on the development or delivery of services;
- visits to study health service delivery arrangements and approaches to care;
- participation in governance meetings of multilateral organisations of which Australia is a member, in particular the World Health Organisation;
- negotiations in relation to reciprocal health agreements and other arrangements involving mutual recognition of regulatory arrangements;

- negotiation of Memoranda of Understanding and related instruments to facilitate health co-operation with other countries;
- development of health export opportunities; and
- promotion of health export opportunities.

(c) A list of World Health Organisation and other United Nations health consultations, which Department officers attended or provided input to is at Attachment A.

Attachment A **Question E046**

Meeting	Date and Location
53rd Session of WHO World Health Assembly	15-20 May 2000, Geneva
103rd Session of WHO Executive Board	24-29 January 2000, Geneva
50th Session of the World Health Organisation Regional Committee for the Western Pacific	13-17 September 1999, Manila
Working Group on the Operation of WHO's Regional Committee System	11-15 January 2000, Manila
International Agency for Research on Cancer Governing Council	8-12 May 2000, France
WHO 5th Global Conference on Health Promotion	5-9 June 2000, Mexico
International Conference on Population Development 5 year Review	30 June to 2 July 2000 (input only)
International Labour Organisation – International Convention on Medical and Sickness Benefits	May 2000 (input only)
World Summit for Social Development + 5	26 June – 1 July 2000 (input only)
WHO Meeting on Application of IT on Resource Sharing Among Medical/Health Libraries in the Western Pacific Region	22-26 November 1999, China
WHO Meeting on International Classification of Diseases	23-27 October 1999, Norway
WHO Steering Group for Blood Safety Policy	15-20 November 1999, Geneva
WHO Indigenous Health Consultation	22-26 November 2000, Geneva
WHO Drinking Water Quality Committee	7-11 June 2000, Germany
UN Commission on Narcotic Drugs 43rd Session	6-15 March 2000, Vienna
UN Environmental Program, 3rd and 4th International Negotiating Committee Meetings on Persistent Organic Pollutants	6-10 September 2000, Germany
WHO Western Pacific Region Meeting of National Focal Persons for Tobacco	3-7 August 1999, Manila
WHO Workshop for STI and HIV/AIDS Program Managers	28 September-2 October 1999, Manila
Meeting on measuring the impact of the WHO Vaccines and Biologicals Priority Project	27-30 May 2000, Geneva
WHO Working Group on the Framework Convention on Tobacco Control	21-25 March 2000, Geneva
Consultation on the WHO International Program on Chemical Safety Uncertainty and Variability Planning Workgroup	29 Feb – 1 Mar 2000, United Kingdom
WHO Consultation on the Composition of the Annual Influenza Vaccine	19-21 June 2000, Japan
WHO Joint Meeting on Pesticide Residues	20-22 September 1999, Italy
WHO Workshop on Information Exchange in Management and Use of Pharmaceuticals, Biologicals and Herbal Medicines for Pacific Island Countries	23-25 October 1999, Fiji
WHO Consultation on Methodologies for Research and Evaluation of Traditional Medicine	10-14 April 2000, China

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

WHOLE OF PORTFOLIO **Question: E021**

Topic: PARLIAMENTARY LIBRARY

Written Question On Notice

Senator Evans asked:

(a) What action has the Department taken following the advice given by the Speaker concerning independence of the Parliamentary Library?

(b) Has the Secretary given his officers advice that requests from the Parliamentary Library should be responded to in a timely fashion without reference to the Minister's office for approval?

Answer:

(a) No action was deemed necessary.

(b) See (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

WHOLE OF PORTFOLIO **Question: E146**

Topic: QUESTIONS ON NOTICE ANSWERS

Hansard Page: CA 4

Senator Evans asked:

Do you have a breakdown of when they (answers to QON) went to the Minister's office and when they came to the committee.

Answer:

The following table sets out the dates on which draft answers were sent to the Ministers' offices.

TIMING OF PROVISION OF ANSWERS TO THE MINISTER'S OFFICE

	02-May Hearing	22-23 May Hearing	Total	Cum Total
May	149	-	149	149
June	28	197	225	374
July	6	87	93	467
August	-	-	0	467
September	1	3	4	471
October		3	3	474
November		7	7	481
	184	297	481	

Information regarding the provision of answers to the Committee was provided on 22 November 2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E023**

Topic: NATIONAL CHILD NUTRITION PROGRAM

Written Question On Notice

Senator Evans asked:

In relation to Child Nutrition:

(a) How much has been spent on the Child Nutrition program so far and how much on Departmental expenses related to running the Program

(b) Can you provide a full list of the 92 projects announced by the Minister on the 15th November and how this spending will be distributed over the coming years

(c) When were the grant recommendations sent to the Minister?

(d) Did the Minister change any of the grants recommendations?

Answer:

(a) No money has been spent on the Child Nutrition program to date and no Child Nutrition program funds have been used for Departmental expenses.

(b) A list of all 92 projects to be funded is attached. This list is also on the departmental website. Contracts are still being negotiated with successful applicants, therefore we are unable to give an accurate distribution of funding. However, of the $11.38m announced in this funding round, it is estimated that 30% will be spent this financial year; 30% in 2001-2; 30% in 2002-3 and 10% in 2003-4.

(c) Recommendations were sent to the Minister on 3 August 2000

(d) All applications for funding were assessed under 5 categories - highly suitable, suitable, needs development, unsuitable and ineligible. Applications ranked as 'highly suitable' and 'suitable' were recommended to the Minister for selection. All 'highly suitable' projects were funded, together with a small number of 'suitable' projects.

ATTACHMENT to Question: E023

Successful Applicants
1st Round of the National Child Nutrition Program

NATIONAL PROJECTS	
Organisation:	**International Diabetes Institute**
Project Title:	Primary Fight Back – Healthy Eating & Physical Activity!
Organisation:	**Healthy Eating Healthy Living Program**
Project Title:	Food4kids.org - Promoting and fostering healthy eating habits in primary school children Australia wide, through the creation of an interactive, child centred website and CD Rom
Organisation:	**Home Economics Institute of Australia**
Project Title:	The Colouful World of Vegies
ACT PROJECTS	
Organisation:	**YWCA of Canberra**
Project Title:	Training Parents as Nutrition Educators
Organisation:	**Southside Community Services**
Project Title:	Give Me Five - A child nutrition program
NSW PROJECTS	
Organisation:	**St Marys Primary School Bowraville Nutrition Program**
Project Title:	Nutrition Program for Children and Parents
Organisation:	**Hawkesbury Food Program**
Project Title:	Nutrition for Isolated Children in the Hawkesbury - The Forgotten Valley
Organisation:	**Parramatta/Holroyd Family Support Inc**
Project Title:	Triple FFF (Family Friendly Food)
Organisation:	**St Marys North Public School**
Project Title:	Healthy Food for St Marys North School Program
Organisation:	**Family Action Centre – University of Newcastle**
Project Title:	Shop Smart for Home-Start: Bringing families and food together
Organisation:	**Tooty Fruity Vegie**
Project Title:	Tooty Fruity Vegie Project
Organisation:	**Family Health Coalition, Centre for Family Health & Midwifery**
Project Title:	A Healthy Start to Life: Supporting families feeding infants
Organisation:	**Tumut Community Health Centre**
Project Title:	Treating your Tot to Terrific Tucker
Organisation:	**Wellington Aboriginal Corporation**
Project Title:	Implementation of the Strong Women, Strong Babies Strong Culture Program in the Macquarie Area
Organisation:	**Telepoa Family Support Service**
Project Title:	Telopea Family Good Eating Project
Organisation:	**Wagga Women's Health Centre Inc**
Project Title:	Wagga Wagga Community Kitchens
Organisation:	**Westport Public School Canteen**

Project Title:	2000 Go For Gold Brekky Club
Organisation:	**Western Sydney Area Health Promotion**
Project Title:	Mt Druitt Food Project - Young Families
Organisation:	**Lismore & District Women's Health Centre**
Project Title:	Growing and Nurturing Healthy Jarjums
Organisation:	**National Family Day Care Council**
Project Title:	Good Food in Family Day Care
Organisation:	**Newcastle Family Support Service Inc**
Project Title:	Faster Food From Home
Organisation:	**Lady Gowrie Child Centre**
Project Title:	Start Right - Eat Right
Organisation:	**Food-Share Australia**
Project Title:	Food Share: Quality nutritional food for disadvantaged children in greater Sydney
Organisation:	**Diabetes Australia**
Project Title:	Tharawal Aboriginal Family Nutrition Project
Organisation:	**Moree Public School Canteen Committee**
Project Title:	Fuelled Up for School
Organisation:	**Coonamble Neighbourhood Centre**
Project Title:	Family Food Project
NT PROJECTS	
Organisation:	**Danila Dilba Biluru Butji Binnilutlum Medical Service Aboriginal Corporation**
Project Title:	Danila Dilba Child Nutrition Project
Organisation:	**Laramba Community Council**
Project Title:	Healthy Kids, Healthy Families
Organisation:	**Yuelamu Community Inc**
Project Title:	Womens' Healthy Lifestyle Project
Organisation:	**Waltja Tjutangku Palaypayi Aboriginal Association**
Project Title:	Pipirri Tjuta Palya Kanyila, Tjana Ngurra Palya Kanyintjaku - Keeping Kids Healthy Makes a Better World
Organisation:	**Utju Community Council**
Project Title:	Utji Mai Wiru – Healthy Food for Kids at Areyonga
QLD PROJECTS	
Organisation:	**Lockhart River Education Council**
Project Title:	Lockhart River Students Learn about Nutrition at School
Organisation:	**Nursing Mothers Association of Australia (Qld)**
Project Title:	The Southern Brisbane and Logan Breastfeeding Promotion and Training Coalition
Organisation:	**University Southern Qld, Toowoomba & St Vincents Hospital**
Project Title:	Breastfeeding Support and Educaiton in the Southern Zone of QLD
Organisation:	**Townsville Aboriginal & Islanders Health Services Ltd**
Project Title:	Townsville Indigenous Breastfeeding Peer Counselling Program
Organisation:	**Townsville Aboriginal & Islanders Health Services Ltd**
Project Title:	Developing Healthy Eating, Drinking & Exercise Behaviours in Townsville's Indigenous Children

Organisation:	**Gurriny Yealamucka Health Service**
Project Title:	Development and Implementation of a Nutrition Program for Yarrabah
Organisation:	**Coolangatta Nutrition Program**
Project Title:	Coolangatta Nutrition Project: Eat Well, Feel Well, Work Well
Organisation:	**Darling Downs Public Health Unit**
Project Title:	Building Foundations for Positive Health Outcomes
Organisation:	**Nutrition Australia**
Project Title:	Food For Life
Organisation:	**North West Aboriginal and Torres Strait Islander Community Assocation**
Project Title:	Food for Thought
Organisation:	**QLD Association of School Tuckshops**
Project Title:	The Queensland School Breakfast Project
Organisation:	**Saibai Island State School**
Project Title:	Saibai Island Child Nutrition Project
Organisation:	**Wuchopperen Medical Service**
Project Title:	Kowrowa Child Nutrition Program
Organisation:	**Murgon State School**
Project Title:	Murgon Community Child Nutrition Project
Organisation:	**Depot Hill State School**
Project Title:	Live Longer - Eat for Life
Organisation:	**Cherbourg State School P&C Association**
Project Title:	Cherbourg Community Child Nutrition Project
SA PROJECTS	
Organisation:	**University of Adelaide**
Project Title:	Breastfeeding in Public: Improving Community Attitudes
Organisation:	**Lady Gowie Child Centre Inc**
Project Title:	Talking to Families about Nutrition
Organisation:	**Noarlunga Health Services**
Project Title:	Healthy Food Choice in Family Day Care
Organisation:	**Lady Gowie Child Centre Inc**
Project Title:	Pilot development, implementation and evaluation of a childcare nutrition award scheme which improves nutrition and eating environment for children in southern metropolitan child care centres of Adelaide
Organisation:	**Whyalla Hospital & Health Services, Eat Well SA**
Project Title:	Food Supply and Access in the Northern and far Western and Upper Eyre Health Regions in SA
Organisation:	**Pika Wiya Health Service**
Project Title:	Birth to Elders – Nutrition for Life Project
Organisation:	**South East Regional Health Service**
Project Title:	Blue Lake Bulk-Mount Gambier Food Cooperative
TAS PROJECTS	
Organisation:	**Tasmanian School Canteen Association Inc**
Project Title:	Cool Canteens for Kids
Organisation:	**Nursing Mothers Association of Australia – Tasmania**

Project Title:	Mum's the Word
Organisation:	**Tasmanian Nutrition Promotion Taskforce**
Project Title:	Eat Well Tasmanian Kids
Organisation:	**Lady Gowie Tasmania**
Project Title:	Tastebuds -a food and nutrition training initiative for Tasmanian childcare services
Organisation:	**Child Health Association Inc**
Project Title:	Family Food Patch
VIC PROJECTS	
Organisation:	**Western District Health Service**
Project Title:	Eat Well - Grow Well
Organisation:	**ISIS Primary Care**
Project Title:	Breast is Best
Organisation:	**Winda Mara Aboriginal Corporation**
Project Title:	Healthy Kids, Healthy Community
Organisation:	**Sunraysia Community Health Services**
Project Title:	Sunraysia Family Nutrition Project
Organisation:	**Maryborough District Health Service**
Project Title:	Tasty Affordable Food
Organisation:	**National Heart Foundation of Australia**
Project Title:	Out of School Hours Care Nutrition Project
Organisation:	**Doutta Galla Community Health Services Inc**
Project Title:	Moonee Valley Child Nutrition Alliance
Organisation:	**Yarram & District Health Service**
Project Title:	Go Bananas - A program for childhood nutrition
Organisation:	**Swan Hill District Hospital**
Project Title:	Healthy Eating for Country Kids
Organisation:	**Robinvale District Health Services**
Project Title:	A Healthy Family is Built on a Good Diet of Nutritious Foods
Organisation:	**Njernda Aboriginal Corporation**
Project Title:	Healty Koori Nutrition Program
Organisation:	**Windermere Child and Family Services Inc**
Project Title:	Feeding the Family
Organisation:	**South West Healthcare**
Project Title:	High Five - South West Victoria School Nutrition Project
Organisation:	**Murray Valley Aboriginal Co-Op**
Project Title:	Who's Eating Gilbert Grape and Vicky Vegetable
Organisation:	**Kindergarten Parents Victoria Inc**
Project Title:	Food Facts for Preschoolers: A training program for teachers, parents & children
Organisation:	**Australian Vietnamese Womens Welfare**
Project Title:	Good Nutrition and Health in Vietnamese Australian Families
Organisation:	**Western Regional Health Centre**
Project Title:	Child Nutrition in the West
Organisation:	**Bethany Family Support Inc**
Project Title:	Promoting Body Satisfaction and Health

WA PROJECTS	
Organisation:	**The Gowie WA Inc**
Project Title:	Improving nutrition in family day care
Organisation:	**Northam Share & Care Inc**
Project Title:	Follow the Yellow Brick Road to Healthy Childhood Nutrition
Organisation:	**Western Australian School Canteen Association**
Project Title:	Improving nutritional intake of school aged children in remote areas through school canteen accreditation
Organisation:	**Ngala Family Resource Centre**
Project Title:	Banksia Grove Breakfast Club
Organisation:	**Cancer Foundation of Western Australia**
Project Title:	Parental Guidance Recommended - A proactive child nutrition program
Organisation:	**Ngala Family Resource Centre**
Project Title:	First Steps to Solids
Organisation:	**Association for Services to Torture and Trauma Survivors**
Project Title:	The EatSmart Program
Organisation:	**Clarkson Primary School**
Project Title:	Clarkson Primary School Health & Wellbeing Plan
Organisation:	**Meerilinga Young Children's Foundation**
Project Title:	National Child Nutrition Program
Organisation:	**Christmas Island Womens Association**
Project Title:	Healthy Makan
Organisation:	Yura Yungi Medical Service
Project Title:	Numborrahginj Yambagina Project
Organisation:	**Kiwirrkurra Remote Community School**
Project Title:	Kiwirrkurra School Lunch Program
Organisation:	**Looma Community Council/Menzies Centre for Health Research**
Project Title:	Food for Growth in Under 5's
Organisation:	**Lomdadina & Djerubdjin Community Councils**
Project Title:	Establishment of a Healthy Canteen at Lombadina/Djerindjin
Organisation:	**Mullewa District High School**
Project Title:	Partners in Health - Working Together for Healthier Mullewa Kids

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E024**

Topic: CJD SETTLEMENT

Written Question On Notice

Senator Evans asked:

What is the current state of play with the payment of compensation for people who may have been exposed to CJD as a result of their participation in growth hormone trials?

Answer:

No compensation is to be paid to people who may have been exposed to CJD as a result of their participation in the Australian Pituitary Hormone Program.

There is a Pituitary Hormones Trust Account that contains funds to provide ongoing counselling and support for pituitary hormone recipients and their families and provided a settlement for the children of the recipients acknowledged to have died from CJD. The Trust Account funds are to provide for the cost of the support services until 2010 and counselling services through until 2003.

All litigants were made an offer of settlement by the Commonwealth which provides that should they contract CJD in the future their medical and other care costs will be met.

All but two plaintiffs either accepted the settlement offer, or, alternatively, withdrew their writs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E006**

Topic: FAMILY PLANNING

Written Question on Notice

Senator Harradine asked:

(a) Has the total allocation for Family Planning organisations in the 2000-2001 financial year been determined?

(b) Has the funding for natural family planning bodies been determined?

Answer:

(a) & (b) The following allocations have been approved for family planning agencies for 2000-2001.

Payments direct from the Commonwealth:

Family Planning Australia	$ 89,224
Family Planning NSW	$4,741,214
Family Planning VIC	$1,741,716
Family Planning QLD	$2,727,530
Family Planning WA	$1,557,412
Family Planning TAS	$ 509,506
Family Planning NT	$ 361,204
Working Women's Health Inc	$ 101,430
Aust Catholic Bishops Conference	$ 818,463
Pregnancy Support Service	$ 225,108
SUB –TOTAL	**$12,872,808**

Payments via State/Territory Governments through the Public Health Outcome Funding Agreements (PHOFAs):

SHine (SA)	$1,463,000
Family Planning (ACT)	$ 442,000
SUB – TOTAL	**1,905,000**
TOTAL	**$14,777,808**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E007**

Topic: SEXUALLY TRANSMITTED INFECTIONS

Written Question On Notice

Senator Harradine asked:

> **Has the document to guide schools in implementing programs relating to sexually transmitted infections been finalised?**

Answer:

> Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E008**

Topic: CLONING ANIMALS

Written Question On Notice

Senator Harradine asked:

> **Further to the answer to my question of 2 May 2000 re cloning animals: In relation to whether cloning involves genetic replication or genetic modification, does this not depend on the cloning technique used? If cloning is done by embryonic fission or splitting to form monozygotic twins then this would seem not to involve genetic modification. However, if the technique involves somatic cell nuclear transfer, such as was used in the "Dolly" case by Professor Ian Wilmut, then a new genetic combination may be established involving the mitochondrial DNA and RNA of the animal that provides the host ovum and the nucleic DNA and RNA of the somatic cell nucleus donor.**

Answer:

> Cloning by somatic nuclear transfer will produce an organism with the cell organelles from the host cell, including mitochondria (which have their own generic material) and the genome of the donor cell. However, this is not considered as genetic modification under the current Genetic Manipulation Advisory Committee guidelines, nor is it intended to consider this as a genetic modification under the new regulatory system.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E009**

Topic: ABORTIFACIENTS

Written Question on Notice

Senator Harradine asked:

(a) Has the TGA examined the article 'An Insider's Account' in The Sunday Age 5 November 2000, which was critical of the use of Misoprostol in a Melbourne abortion clinical?

(b) Is the TGA aware of other clinics in Australia which use Misoprostol or Methotrexate to induce abortion?

(c) Has the Adverse Drug Reaction Advisory Committee received any reports of death or ill effects from the use of Misoprostol or reports of deaths or ill effects from the use of Methotrexate? If so, please provide details.

(d) Is the TGA aware of the statement of Searle in the US that it disapproves the use of Misoprostol in the induction of abortion because of the serious risks involved?

(e) Does the TGA plan to examine or provide any advice on the issue of off-label use of these drugs in view of the manufacturer's concerns?

Answer:

(a) Yes.

(b) The TGA is aware that Misoprostol and Methotrexate have sometimes been used off label as abortifacients in Australia.

(c) In the period January 1986 to October 2000, the Adverse Drug Reactions Advisory Committee (ADRAC) has received 68 reports of suspected adverse reactions in connection with the use of Misoprostol. One report described a fatal outcome associated with hepatitis for which Misoprostol was one of six drugs suspected. (Flucloxacillin was considered the most likely drug cause in this report.)
In the period 1st January 1996 to 21st November 2000, ADRAC received 224 reports of suspected adverse reactions in connection with the use of Methotrexate. Of these, 12 reports described fatal outcomes, 10 of which also implicated at least one other

drug. For the purposes of this analysis, approved indications were taken to be oncology, psoriasis and rheumatoid arthritis.

(d) Yes.

(e) No. It is not illegal under the Therapeutic Goods legislation for a medical practitioner to prescribe Misoprostol or Methotrexate for "off-label" use. However, there may be medical practice and medico-legal implications associated with prescribing a medication outside its approved usages. Such matters are the responsibility of State and Territory authorities including Medical Boards and Departments of Health.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E010**

Topic: NATIONAL SEXUAL HEALTH STRATEGY PROJECT

Written Question on Notice

Senator Harradine asked:

Please provide details of the National Sexual Health Strategy Project.

Answer:

A Sexual Health Reference Group was established in August 1999 to consider the need for a national sexual health strategy. Membership of the SHRG included representatives of a wide range of community and professional groups and experts with an interest in sexual health as well as representatives from the Department and the National Public Health Partnership Group.

The Reference Group took the view that any development of a national sexual health strategy would need to take account of existing sexual health related activities, programs and policies. A scoping or mapping exercise was commissioned to:

- examine current Commonwealth funded national initiatives relating to sexual health and the linkages and gaps between those initiatives; and
- develop a clear understanding of what the scope and purpose of a national sexual health strategy might be.

It was not part of the consultant's brief to consider State or Territory programs in detail. The Reference Group had responsibility for overseeing this project.

The Department received the consultant's final report in September 2000. While the report identifies significant gaps in policies and programs and the need for improved integration and coordination of current activities at national level, both within the Department and across portfolios, it does not make a compelling case for a separate national sexual health strategy.

The report has been referred to the National Public Health Partnership for consideration and further action. The Partnership's National Strategies Coordination Working Group is examining the report and will provide advice and recommendations to the Partnership at its next meeting in February 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTION ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E011**

Topic: GOVERNMENT RESPONSE TO THE REPORT BY THE SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE ON CHILDBIRTH PROCEDURES "ROCKING THE CRADLE"

Written Question On Notice

Senator Brian Harradine asked:

> **Could the Department inform the committee on what it has done so far, and proposes to do, to implement the recommendations on the Senate report 'Rocking the Cradle: A Report into Childbirth procedures'? What is the progress to date?**

Answer:

> The Government's Response to the Senate Community Affairs References Committee Report on Childbirth Procedures "Rocking the Cradle" was tabled in both Houses of Parliament on 31 August 2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E020**

Topic: ABORTION AND BREAST CANCER

Written Question on Notice

Senator Harradine asked:

> **Could the Department explain why publicly-funded anti-cancer organisations are not informing women of the link between induced abortion and breast cancer?**

Answer:

There is no consistent evidence that demonstrates a direct link between breast cancer and either induced or spontaneous abortion.

- Expert advice indicates that almost all of the studies on induced abortion and risk of breast cancer are case control studies, which have produced conflicting results.

- Many of the articles that support a link are older studies, and some of the more recent articles question the methodologies employed in these studies.

More recent studies indicate little support for the hypothesis that induced abortion increases breast cancer risk overall, or in particular subgroups. Michels and Willet (1996) reviewed evidence to better understand the apparent inconsistencies and concluded: "Studies to date are inadequate to infer with confidence the relation between induced or spontaneous abortion and breast cancer risk but it appears that any such relation is likely to be small or non-existent."

The World Health Organisation (WHO) recently produced a fact sheet (dated June 2000) on induced abortion and breast cancer risk. It concluded that results from epidemiological studies showed no consistent effect of first trimester induced abortion upon a woman's risk of breast cancer later in life.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E097**

Topic: GMAC

Written question on notice

Senator Harradine asked:

> **The question I asked (Q21 2 May) in relation to Professor Trounson's experiments concerning animal cloning involving somatic cell nuclear transfer and hence did refer to procedures which created a new genetic combination. The reality of forming new genetic combinations in this way is no more evident than in the use of cross-species somatic cell nuclear transfer as has been reported to have been done by Professor Trounson's centre using a pig ovum and a human somatic cell.**
>
> **Was GMAC notified of this work and did it approve of cross-species human-porcine somatic cell nuclear transfer?**

Answer:

> As Senator Harradine noted in Parliament on 4 December 2000, he was in error when he attributed the work with the pig ovum and human cell to Professor Trounson's laboratory. Professor Trounson has advised that the work is included in a patent submitted by a Melbourne company, Stem Cell Sciences Pty Ltd and that no such work had ever been done in any of Professor Trounson's laboratories.
>
> Ethical guidelines relating to human animal experimentation, including cloning are the responsibility of the National Health and Medical Research Council, rather than the Genetic Manipulation Advisory Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E096**

Topic: ZERO TOLERANCE TO ILLICIT DRUGS

Written Question On Notice

Senator Denman asked:

I took the trouble of checking the Hansard for the 25/5/98. At no point does the Prime Minister make it clear that zero tolerance is just for schools.

(a) Does the Minister for Health agree with Mr Howard that Australia should have a zero tolerance approach to illicit drugs?

(b) Does the Minister for Health support a harm reduction approach to alcohol, tobacco and prescribed and illicit drugs?

Answer:

(a) The Prime Minister has made the government's position on zero tolerance clear on a number of occasions. The issue was discussed at the meeting of the Council of Australian Governments on 9 April 1999. At that time Heads of Government agreed that illicit drugs have no place in schools and noted that while "some would describe this as a zero tolerance approach, others would use a different description."

In relation to illicit drugs in the community, the Prime Minister said on 23 August 2000 at the launch of the Diversion Agreement with Victoria:

> "But there can be no area of difference I believe in relation to the undesirability of sending people to gaol who are merely suffering from an addiction and who've not really seriously moved from addiction into crime. And it is to prevent the tragedy of that occurring that these (diversion) agreements are being entered into."

(b) The *National Drug Strategic Framework 1998-2003,* which is supported by the Commonwealth and all State and Territory governments, recognises the need to provide a wide range of approaches to dealing with drug problems including supply reduction, demand reduction and harm reduction. With regard to illicit drugs, the National Illicit Drug Strategy emphasises approaches based on prevention, supply reduction and significantly increasing the provision of treatment and rehabilitation services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY Question: E098

Topic: DEATHS FROM DRUG OVERDOSE

Written Question On Notice

Senator Denman asked:

Drug overdose deaths numbered 6 in 1964 and 737 in 1998. That is one drug overdose death in every 12 hours. Those deaths increased from 8 per 10,000 deaths among 15-44 year olds in 1964 to 726 per 10,000 in this age group in 1997.

(a) Can the Minister confirm that the policy of the Australian Government is first and foremost to protect Australian youth and if so,

(b) Does he think this policy has worked if deaths increased in 33 years from 8/10,000 to 726/10,000?

(c) Does the Australian Government believe that the number of these deaths could have halved in six years as Switzerland achieved between 1992-1998?

(d) How does the Australian Government propose to reduce this number of deaths?

(e) Are there any goals and targets for drug overdose deaths in Australia?

Answer:

(a) The mission for the National Drug Strategic Framework 1998-99 to 2002-03, which has been endorsed by Health and Law Enforcement Ministers from both the Commonwealth and all States and Territories, is "to improve health, social and economic outcomes by preventing the uptake of harmful drug use and reducing the harmful effects of licit and illicit drugs in Australian society".

(b) There have been many social and economic influences on the availability and demand for drugs over the past 33 years in Australia and the world. It is not possible to address the range of policy approaches adopted by Commonwealth, State and Territory Governments over that period to assess the impact of those policies on overdose deaths.

(c) See above.

(d) The Ministerial Council on Drug Strategy (MCDS) has endorsed the development of a National Heroin Overdose Strategy. The Strategy is currently being finalised with a Working Group comprised of members of the Intergovernmental Committee on Drugs, the Australian National Council on Drugs and the National Expert Advisory Committee on Illicit Drugs.

(e) The National Heroin Overdose Strategy will specify priorities for action and key strategy areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E100**

Topic: ILLICIT DRUG USE AND HCV INFECTIONS

Written Question on Notice

Senator Denman asked:

Australia currently has an estimated 11,000 HCV infections per year due to injecting drug use - that is one every 48 minutes.

(a) Does the Minister believe that harm reduction has a role to play in reducing HCV infections?

(b) Does the Minister believe that Australia could achieve the same low prevalence for HCV as we achieved for HIV in this population? How long might that take? How would it be achieved?

Answer:

(a) The *National Hepatitis C Strategy 1999-2000 to 2003-2004* recognises harm reduction as an essential component underpinning Australia's response to hepatitis C. Harm reduction interventions are designed to reduce drug related harm such as transmission of hepatitis C for individuals and the wider community. The *National Drug Strategic Framework 1998-99 to 2002-03* also acknowledges the importance of public health measures such as harm reduction strategies for preventing the spread of blood borne viruses such as hepatitis C.

(b) Preventing further transmission of hepatitis C remains a primary aim of the *National Hepatitis C Strategy 1999-2000* to *2003-2004.* With more than 200,000 Australians already infected and over 90 per cent of all new hepatitis C infections occurring among people who inject drugs, it is essential to pursue reduction initiatives.

This Strategy is a five year framework supporting a partnership approach to reduce hepatitis C in the community. It provides for a strong and inclusive response from all levels of government, community organisations, medical, health care, scientific and research communities, and people affected by hepatitis C. Successful implementation of the Strategy will depend on cooperation between the Commonwealth and State and Territory governments.

An independent, external mid-term review will evaluate and monitor the effectiveness of the Strategy. Annual surveillance activities and reports by the Communicable Diseases Network of Australia and New Zealand will also provide ongoing data.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E101**

Topic: HIV and IDU

Written Question On Notice

Senator Kay Denman asked:

Many of Australia's major trading partners in the Asian region unfortunately have a major problem with twin epidemics of HIV and IDU. Accepting that the policy options for these countries are up to these sovereign nations:

(a) would the Minister feel more relaxed and comfortable if these countries adopted a harm reduction approach to HIV/IDU or a zero tolerance approach?

(b) will Australia support countries in our region who seek our help with harm reduction approaches?

Answer:

It is unfortunate that many countries in the Asian region face the significant challenge of combating an HIV epidemic in an environment of increasing intravenous drug use (IDU).

Whilst Australian support to foreign government activities in this area is primarily a matter for the Minister of Foreign Affairs and Trade, high rates of HIV transmission and of IDU in neighbouring countries have consequences for the Australian domestic setting. The principles expressed in the *National HIV/AIDS Strategy 1999-2000 to 2003-2004* and the initiatives based on them, are proven to reduce HIV transmission rates in high risk communities, including harm minimisation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E102**

Topic: ILLICIT DRUG USE

Written Question on Notice

Senator Denman asked:

Would the Minister support the provision of cannabis to someone with an advanced and terminal condition (such as AIDS or Cancer) and distressing symptoms unrelieved by conventional medication if reputable medical opinion suggested that cannabis might relieve these symptoms?

Answer:

In May 1998 the Ministerial Council on Drug Strategy (MCDS) supported jurisdictions reviewing their regulations to enable further research into the use of cannabis for medical purposes. The laws governing the possession and use of cannabis remain the responsibility of State and Territory Governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E103**

Topic: ILLICIT DRUG USE

Written Question on Notice

Senator Denman asked:

Does the Minister support evidence based medicine?

Answer:

Yes

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E104**

Topic: ILLICIT DRUG USE

Written Question on Notice

Senator Denman asked:

Does the Minister support medical research following due scientific process including the avoidance of any political interference?

Answer:

Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E105**

Topic: ILLICIT DRUG USE

Written Question on Notice

Senator Denman asked:

The report of the External Panel on the Evaluation of the Swiss Scientific Studies of Medically Prescribed Narcotics to Drug Addicts, convened by WHO, reported in April 1999 in reference to the Swiss Heroin prescription study that "There is a need for further studies to establish objectively the differences in the effect of these different opioids". Does the Minister agree with this statement from the eminent panel?

Answer:

This statement by the External Panel was made in the context of emphasising the need for caution in the prescription of heroin and "continued scepticism around the specific benefits of one short acting opioid over others…" The World Health Organisation commissioned evaluation of the Swiss heroin trial identified that:

- given the provision of the non-drug treatment support, it cannot be concluded that prescribed heroin contributed to the improved health and welfare of participants;
- with the absence of a control group, it is not clear if the same results could have been achieved without the prescription, ie, the improvements recorded in the health and well being of participants could have been due to the intensive non-drug treatment they received; and
- there is no convincing evidence that heroin prescription generally leads to better outcomes than methadone treatment.

The report appears to be a considered one.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E106**

Topic: ILLICIT DRUG USE

Written Question on Notice

Senator Denman asked:

Bearing in mind that the Swiss have achieved remarkable progress in reducing deaths, disease, crime and drug use since funding law enforcement equally with treatment and prevention,

(a) What does the Minister believe is the right balance between health and law enforcement interventions?

(b) Does the Minister believe that Australia is more likely to be successful responding to illicit drugs with a primary law enforcement focus or with a primary health and social focus?

Answer:

(a) There is not a 'one size fits all approach' to the drugs issue. The balance between health, law enforcement and other initiatives will vary depending on a range of factors.

(b) Professors Single and Rohl, who evaluated the National Drug Strategy 1993-1997, identified as one of the Strategy's success factors, the balanced approach between supply reduction, demand reduction and harm reduction strategies. The current *National Drug Strategic Framework 1998-99 to 2002-03* continues to pursue this balanced approach.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E111**

Topic: ILLICIT DRUG USE

Written Question On Notice

Senator Denman asked:

(a) Is there any evidence that injecting rooms "send the wrong message" as claimed by the Prime Minister?

(b) Does the Minister agree that there have not been any reported deaths in an injecting room in Europe since 1986?

(c) Does the Minister agree with the Member for Bennelong that the trials of injecting rooms by the States have no place even though there have been no deaths in the 45 or so injecting rooms in Europe?

Answer:

(a) The Department is unaware of any research that either confirms or disproves this statement.

(b) The Department does not have such information.

(c) The Commonwealth Government does not support injecting rooms and does not consider them to be an appropriate response to the problems caused by illicit drugs. The States and Territories are primarily responsible for health and law enforcement matters and ultimately the trialing and establishment of injecting rooms is a matter for States and Territories to decide.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E107**

Topic: ILLICIT DRUG DIVERSION INITIATIVE

Written question on notice

Senator Denman asked:

(a) Does the Minister agree that involuntary treatment of drug users carries a risk of creating perverse incentives so that otherwise law-abiding drug users who are seeking help for their problems would be unable to obtain help unless they had committed a crime?

(b) How does the Minister propose to ensure that involuntary treatment does not crowd out voluntary treatment?

Answer:

(a) No. The Framework for the Illicit Drug Diversion initiative developed by the Council of Australian Governments (COAG) explicitly recognises that voluntary admissions to assessment, education and treatment programs should not be displaced by offenders referred through the Diversion Initiative.

(b) To ensure that such 'crowding out' does not occur, the Commonwealth Government has set aside around $105 million to ensure the diversion strategy is well resourced with additional services covering education, treatment and rehabilitation. Offenders who do not agree to the recommended treatment will proceed through the criminal justice system.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E108**

Topic: TOBACCO CONTROL

Written Question on Notice

Senator Denman asked:

What can be done to reduce the potentially most preventable public health problem in Australia-cigarette smoking-given that smoking prevalence has not declined for over five years?

Answer:

A range of measures that involve action to encourage cessation and prevent smoking uptake is regarded as best practice by the World Health Organisation and forms the basis of Australia's National Tobacco Strategy 1999 to 2002-03.

Smoking prevalence has declined over the last five years. In the 18 month period since the National Tobacco Campaign was launched (June 1997 to December 1998) there was an estimated reduction in adult smoking prevalence of 1.7 percent. This represents approximately 235,000 fewer smokers in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001, 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E109**

Topic: EDUCATION CAMPAIGN

Written Question on Notice

Senator Denman asked:

Can the Minister or DHAC provide any scholarly published evidence to demonstrate that education campaigns have a significant and sustained effect on consumption of illicit drugs by young people?

Answer:

With respect to published evidence to demonstrate that education campaigns have a significant and sustained effect on consumption of illicit drugs by young people, the following references are provided.

Brounstein, P.J. and , Zweig, J.M. (1999). *Understanding Substance Abuse Prevention.* Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Brounstein, P.J., Zweig, J.M. and Gardner, S.E. (1998). *Science-based Practices in Substance Abuse Prevention: A Guide, Working Draft*. Center for Substance Abuse Prevention, Substance Abuse and Mental Health Services Administration.

Carroll, T. (1996). *The Role of Social Marketing Campaign within Australia's National Drug Strategy*, Department of Health and Family Services (unpublished).

Nutbeam, D. (1998). Evaluating health promotion - progress, problems and solutions, Health Promotion International, 13:1, 27-44.

Plant, A., Macaskill, P., Lo, S.K, and Pierce, J. (1988) Report on the evaluation of the anti-heroin campaign, Department of Public Health, University of Sydney.

World Health Organistation (1998). *Health Promotion Evaluation: Recommendations to Policy-Makers, Report on the WHO European Working Group on Health Promotion Evaluation*, Denmark.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E110**

Topic: NEEDLE AND SYRINGE PROGRAMS

Written Question on Notice

Senator Denman asked:

> **Is the Minister or DHAC aware of any well accepted evidence that NSPs "send the wrong message" or increase illicit drug use?**

Answer:

It is recognised that needle and syringe programs continue to be highly effective in reducing risk behaviour and the transmission of blood-borne viruses such as HIV among people who inject drugs. There is also evidence emerging that these interventions are having a significant impact on transmission of hepatitis C in Australia. Research has also demonstrated that harm-reduction interventions do not promote injecting drug use.

These programs need to be seen as part of a package which gives strong messages about the harm of drugs, and which seek through contact under NSPs, to educate and treat drug users.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 1: POPULATION HEALTH AND SAFETY **Question: E148**

Topic: LIFE EXPECTANCY OF IMMIGRANT PARENTS

Hansard Page: CA 21

Senator Crowley asked:

> **Information available in Australia relating to [the life expectancy of] immigrant parents**

Answer:

> Extensive searches of the scientific literature and Australian Bureau of Statistics (ABS) and Australian Institute of Health and Welfare (AIHW) publications have failed to identify any further information relating specifically to the life expectancy of immigrant parents in Australia. An AIHW publication, Australia's Health 2000, states that migrants are in good health and generally have lower death rates and hospitalisation rates when compared with the Australian-born population. This 'healthy migrant effect' is due to the stringent health requirements for immigration to Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO HEALTH SERVICES **Question: E012**

Topic: FOETAL PAIN AND ANAESTHESIA

Written Question on Notice

Senator Harradine asked:

> **I refer to the answer received to question 6.b asked during the Portfolio Budget Estimates 1999-2000 – Supplementary hearings regarding foetal pain and anaesthesia. Does the Department consider this issue not important enough to resolve? How can policy be properly formulated when such contradictions are not resolved?**

Answer:

> The Department notes that while research has been done on the question of foetal pain and anaesthesia, the medical profession has not been able to provide definitive advice on this issue.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO HEALTH SERVICES **Question: E013**

Topic: CLINICALLY RELEVANT SERVICES

Written Question on Notice

Senator Harradine asked:

> **In previous answers to questions relating to the live birth after abortion of 'Baby J' in the Northern Territory and the abortion of a baby with suspected dwarfism in Victoria, and advocacy in some quarters for sex-selection abortion, the Department states that Medicare benefits are only payable for "clinically relevant services." How is "clinically relevant services" defined and what action is taken if payments are deemed to have been made for services which are not "clinically relevant"?**

Answer:

> The legislation provides that Medicare rebates are payable in respect of clinically relevant professional services that are contained in the Medicare Benefits Schedule, and performed by registered medical practitioners. A clinically relevant service means a service rendered by a medical practitioner that is generally accepted in the medical profession as being necessary for the appropriate treatment of the patient to whom it is rendered.
>
> Any concern that a benefit was paid inappropriately for a service, would be referred to the Health Insurance Commission for appropriate action.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO HEALTH SERVICES **Question: E015**

Topic: MEDICAL BENEFITS SCHEDULE

Written Question on Notice

Senator Harradine asked:

The Medicare Benefits Schedule (MBS) provides for benefits to be paid for the "Management of second trimester labour, with or without induction, for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease."

(a) Does the Department have a definition of "gross foetal abnormality"?
(b) If not, who defines it?
(c) Does the Department consider dwarfism "gross foetal abnormality?"
(d) Does the abortion of the baby in Victoria on the grounds of suspected dwarfism violate anti-discrimination laws?

Answer:

(a) No.
(b) It is a clinical decision for the practitioner.
(c) The Department considers the question of whether a patient's condition constitutes "gross foetal abnormality" as a clinical decision for the practitioner.
(d) This is a matter for the Attorney-General.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E014**

Topic: MEDICARE

Written Question on Notice

Senator Harradine asked:

> **If the Health Insurance Commission was informed that Medicare was reimbursing for sex-selection abortion, what action would be taken?**

Answer:

> If the Health Insurance Commission (HIC) was informed that Medicare was reimbursing for sex-selection abortion the matter would be referred to our Professional Review Division for further investigation as to the clinical relevance of the service performed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E016**

Topic: MEDICARE STATISTICS

Written Question on Notice

Senator Harradine asked:

> **Could the Department explain why it took five months to provide an answer to my question asked May 22 requesting Medicare statistics on abortion for last financial year?**

Answer:

> The delay in the provision of the requested statistics is regretted. Statistics have now been forwarded.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question No: E022**

Topic: BENDIGO RADIOTHERAPY

Written Question on Notice

Senator Evans asked:

In answer 281 provided on 12 September the Department says it is of the basis of claims that Victoria was responsible for the delay in the funding of a radiotherapy unit at the Bendigo Hospital. In fact they should have been aware that this issue was subject to heated exchanges in the Bendigo press between the 3rd and the 10th March 2000 which included a statement issued by the Minister saying that the delays were due to Victoria and his inability to contact John Thwaites. In fact (as the Departmental answer reveals) Mr Thwaites had signed the agreement the previous November and Dr Wooldridge failed to sign until after the delays became public knowledge. The newspaper reports indicate that repeated attempts by Mr Thwaites to talk to the Minister had been unsuccessful.

(a) Why was the Department unaware that the Minister had put out a statement on this issue?

(b) What process was used in developing Answer 281 to check the public debate on this issue?

Answer:

(a) Mr Thwaites signed the Memorandum of Understanding (MoU) on 24 November 1999. Before signing the MoU, Dr Wooldridge sought a written undertaking from Mr Thwaites that agreeing to participate in funding the trials at Ballarat, Bendigo and LaTrobe committed the Commonwealth to no funding arrangements beyond those which applied for radiotherapy services. Dr Wooldridge received this written undertaking from Mr Thwaites dated 11 February 2000. On 21 February 2000 Dr Wooldridge sought an acknowledgment from Mr Thwaites concerning the ability of the population to sustain a radiation oncology centre. Mr Thwaites subsequently spoke to Dr Wooldridge on this issue, so there is no written response by Mr Thwaites. Dr Wooldridge signed the MoU on 14 March 2000.

(b) In preparing its response to question 281, the Department was aware of the public debate on this issue. The answer prepared by the Department concentrated on the facts surrounding this issue.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E025**

Topic: MRI FUNDING

Written Question on Notice

Senator Evans asked:

(a) In Answer 218 the Department has indicated the cost of Professor Blandford's recommendation to increase the number of funded scans would cost $8.4m if the number increased to the full 175,000 scans. What funds have been provided in the 2000-01 Budget for this purpose?

(b) Will these funds be available from July 2001 to fund the additional 7 machines?

Answer:

(a) No specific funds have been provided in the 2000-01 Budget for this purpose. Any MRI scans over the 403,000 included in the Diagnostic Imaging Agreement over the period 1998-99 to 2000-01 are funded from the overall Medicare Benefits appropriation.

(b) No specific funds have been sought to fund the additional units (up to 7) expected to be granted eligibility. Funding will come from the overall appropriation for Medicare benefits.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E026**

Topic: AUSTRALIAN HEALTH CARE AGREEMENT INDEXATION

Written Question on Notice

Senator Evans asked:

In relation to the Australian Health Care Agreements indexation:

(a) What is the explanation of the reduction of $60 million in hospital funding between the approved estimates at May 31 ($31.386 billion) and the figures provided in answer to the Question on Notice from the Estimates Committee, No.247 ($31.326 billion)?

(b) Has the Department revised its expectation that the increase in the "Wage Cost Index No 1" (WCI-1) will average 1.6% for the next three years?

(c) Can the Department table figures to show its estimate of the difference between the use of WCI-1 and the measure proposed by the Arbiter of CPI plus 0.5%?

Answer

(a) On the basis of 2000-01 Budget estimates, estimated payments to the States and Territories over the life of the Australian Health Care Agreements were $31.326 billion. This corresponds to the estimate included in the response to Question on Notice No.247.

These estimates were subsequently updated to include revised population data and approved by the Minister for Health and Aged Care on 31 May 2000. Hence, estimated payments to the States and Territories over the life of the Australian Health Care Agreements increased by around $60 million to $31.386 billion.

(b) The Department of Health and Aged Care receives updates of various measures of price changes, including WCI-1, from the Department of Finance and Administration. Revised Health Care Grants reflecting the updated WCI-1 measure will be submitted to the Minister for Health and Aged Care for consideration and approval shortly.

(c) Yes. As above, total approved payments to the States and Territories over the life of the Australian Health Care Agreements are currently estimated at $31.386 billion. This figure would increase to $32.449 billion if Health Care Grants were indexed by CPI plus 0.5%, based on the Department of Finance and Administration's measures of price changes as at the finalisation of the 2000-01 Budget.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E029**

Topic: AUSTRALIAN HEALTH CARE AGREEMENT INDEXATION

Written Question on Notice

Senator Evans asked:

I note that the Arbiter recommended that a further study be undertaken into how the inflationary impact of the GST should be treated in adjusting the Australian Health Care Agreement payments for the year.

(a) What work has the Department done to study this issue?

(b) Will it undertake some form of review of this important issue?

Answer:

(a) None

(b) No

Senate Community Affair Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E032**

Topic: INDICATORS FOR PUBLIC ACUTE CARE HOSPITALS AND EMERGENCY DEPARTMENT WAITING TIMES DATA

Written Questions on Notice

Senator Evans asked:

The National Health Ministers' Benchmarking Working Group, Third Report on Health Sector Performance Indicators, June 1999, p. 7 includes a Figure listing all the indicators for public acute care hospitals and sorts them into three categories:

- **'Yet to be developed'**
- **'Information not completed'**
- **'Data provided by States and Territories'.**

(a) what progress has been made since that time to complete these indicators?

(b) Data provided on emergency department waiting times is categorised as 'data provided by the States and Territories'. Could this data on emergency department waiting times be made available to the Committee?

Answer

(a) A significant development towards improving performance measurement and reporting for the Australian health care system was the establishment by the Australian Health Ministers' Conference of the National Health Performance Committee (NHPC) in August 1999.

The NHPC has replaced the National Health Minister's Benchmarking Working Group and has responsibility for:

- developing and maintaining a national performance measurement framework for the whole of the health system (not just public acute care hospitals) to support benchmarking for health system improvement; and

- providing information on national health system performance.

The NHPC is currently developing a performance indicator framework for national reporting that will cover:

- health status and outcomes (comprising the dimensions of health conditions, human function, life expectancy and well-being, and death*s*);

- determinants of health (grouped into environmental factors, socio-economic factors, community capacity, health behaviours and person-related factors); and

- health system performance (grouped into nine dimensions of performance comprising effectiveness, appropriateness, efficiency, responsiveness, accessibility, safety, continuity, capability and sustainability).

The framework is intended to be comprehensive, inclusive and flexible to allow the cascading of information and processes between levels of the health system and across dimensions, so that it is a useful guide and tool for performance measurement. The NHPC will promote the use of the framework. However, it will be the responsibility of individual groups to develop indicators specific to the purpose of their programs and/or health priorities.

The NHPC will shortly be presenting a strategic directions report for reporting on the performance of the Australian health system to the Australian Health Minister's Conference. It is expected that this report will subsequently be published and widely circulated.

Australian Health Care Agreements (AHCA) Annual Performance Report

While there are links between the work of the NHPC and performance reporting further to the AHCAs, the AHCA Annual Performance Report is a separate process under the Agreements which will continue for the 1998-2003 period further to the requirements of the Agreements.

Clauses 1 and 2 of Schedule C of the AHCAs state that:

The Commonwealth and the States and Territories agree that the publication of performance against agreed indicators should occur to demonstrate that overall funding is contributing to better health outcomes for all Australians.

Clause 3 of Schedule C of the AHCAs requires that the Commonwealth and the States and Territories work together to develop and refine appropriate high level performance indicators, including:

- waiting times for access to services, including elective surgery and emergency department waiting times;

- indicators of Aboriginal and Torres Strait Islander health;

- indicators of integration of care processes and indicators of access to primary care;

- measures of quality of care, including patient satisfaction;

- indicators of effort in medical training and medical research;
- mental health reform indicators; and
- indicators of access to and quality of palliative care services.

The first AHCA Annual Performance Report, which reports on the 1998-99 period, is expected to be published shortly.

(b) Emergency department waiting times data for 1998-99 are published in the Department of Health and Aged Care's Annual Report. The data can be found on pp. 122 and 123 of the 1998-99 Annual Report.

Question E032 **Attachment 1**

WAITING TIMES FOR EMERGENCY DEPARTMENTS, STATES AND TERRITORIES, 1998-99

	NSW	Vic	Qld	WA (a)	SA	Tas	ACT	NT
Category 1								
No. Treated	12,760	6,328	2,181		3,607	960	687	484
No. Long Waits	355	0	102		50	47	0	5
% Long Waits	3	0	5		3	5	0	1
% Treated on Time	97	100	95		97	95	100	99
Category 2								
No. Treated	72,059	37,090	21,394		23,461	5,400	2,262	2,846
No. Long Waits	15,767	6,571	7,630		6,540	1,105	304	1,494
% Long Waits	22	18	36		28	21	13	53
% Treated on Time	78	82	64		72	79	87	47
Category 3								
No. Treated	363,451	176,580	109,809		86,535	29,200	16,301	14,298
No. Long Waits	129,958	43,207	44,114		31,967	8,932	3,262	4,807
% Long Waits	36	24	40		37	31	20	34
% Treated on Time	64	76	60		63	69	80	66
Category 4								
No. Treated	563,955	316,661	144,119		155,912	44,529	36,318	41,444
No. Long Waits	183,853	132,635	46,479		54,551	9,261	11,163	19,084
% Long Waits	33	42	32		35	21	31	46
% Treated on Time	67	58	68		65	79	69	54
Category 5								
No. Treated	206,494	80,074	52,865		28,694	11,118	26,603	12,647
No. Long Waits	23,547	14,343	6,453		2,670	401	5,133	3,247
% Long Waits	11	18	12		9	4	19	26
% Treated on Time	89	82	88		91	96	81	74

Source: Data provided by the States and Territories under the Australian Health Care Agreements. (a) Data not provided by the State.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E033**

Topic: BULK BILLING

Written Question on Notice

Senator Evans asked:

(a) How many cases has the HIC investigated in the last year where a practice has tried to charge patients a fee or indirect charge in addition to bulk billing for services provided?

(b) How many of these cases have resulted in prosecutions or agreements by the practice to cease making a charge?

(c) Has the Commission investigated practices which advertise that they bulk bill but do not do so after hours?

Answer:

(a) 32

(b) 24

(c) The Health Insurance Commission has investigated one case.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E034**

Topic: RADIOLOGY FEE INCREASES

Written Question on Notice

Senator Evans asked:

In Question 244(e) the Department reported that it had received a number of complaints that radiology practices had increased their fees by more than would simply offset the reduction in rebates? How many of these cases were investigated or referred to the ACCC for investigation? What action if any resulted from these complaints?

Answer:

All anecdotal evidence of disproportionate fee increases by radiology practices is being monitored by the Department. No instances have been referred to the ACCC for investigation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO HEALTH SERVICES **Question: E035**

Topic: COMPLEX DELIVERY ITEM

Written Question on Notice

Senator Evans asked:

Has the Department or the Commission examined the pattern of gap fees charged by obstetricians before and after the introduction of a new item number for complex births in 1998? Has the increase in rebate resulted in a reduction in gap fees charged?

Answer:

The Department regularly reviews claims data for obstetric services, including item 16522. This new item relates to the management of labour and delivery for a complex confinement. Complex confinements comprise approximately 25 percent of all confinements. The table below shows the changes from 1997/98 to 1999/00 in terms of the average out-of-pocket expense for privately insured patients. This average is based on the difference between the fees charged and the schedule fee.

MBS Item	**Description**	**Av. Out-of-pocket expenses for Insured patients (fee charged-schedule fee)***		
		1997/98	**1998/99**	**1999/00**
16519	Management of labour and delivery (standard)	$ 278.29	$304.07	$ 344.49
16520	Caesarean section where the patient's care has been transferred to another practitioner for the management of the confinement	$ 177.15	$179.83	$ 205.65
16522	Management of labour and delivery (complex)	n/a	$219.13	$ 258.62

** This is the gap in payment for people who hold private health insurance.*

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E036**

Topic: ELECTRONIC BILLING

Hansard Page: CA 71

Senator Evans asked:

(a) What is the current state of play with the trials of electronic billing of Medicare from a doctor's surgery?

(b) How many trials are underway and what exactly are the arrangements being trialed?

(c) What measures are being put in place to ensure that any wider introduction of electronic billing does not lead to a steep decline in the rate of bulk billing?

Answer:

(a) Electronic lodgement of Medicare claims from a doctor's surgery is currently available for both bulk billing and patient claims. The arrangement for bulk billing claims has been in place for many years. The current arrangements for patient claims include an expansion of a service which was trialed in 1998/99 and testing of a real-time Web based service.

(b) There are no formal trials underway at present. The Medicare 'Easyclaim' for patient claims has had preliminary testing at one established general practice in the ACT. It is anticipated that wider beta testing of the system may be undertaken in 2001.

The objective of Medicare 'Easyclaim' is to support real time patient claiming facilities from doctors' surgeries using the Internet as the communications medium. This will in many cases enable patient claims to be assessed in real time while the patient is still in the doctor's surgery.

(c) Electronic lodgement of Medicare claims can facilitate more efficient submission of Medicare claims within existing claiming rules. No changes to the existing rules are being made for electronic lodgement of patient claims. Payment of the Medicare benefit will be made using the current methods. Where the patient pays in full at the time of service they can elect to be paid by cheque or EFT. Where the patient is given an account a cheque in the doctor's name is sent to the patient/claimant who is responsible for forwarding the cheque and balance of the account to the doctor. As bulk billing rates are driven by competition it is not expected that electronic claiming will have a measurable impact.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E057**

Topic: SAVINGS FOR THE PUBLIC HOSPITAL SYSTEM

Written Question on Notice

Senator Evans asked:

The flow on cost of the Health Insurance Rebate for Medicare is $130m this year rising to $240m in 2003-04. What is the basis for how you have calculated these figures?

Answer:

The estimates are based on past patterns of Medicare Benefit Schedule claims by the insured population. The estimates will be refined as more evidence becomes available of patterns of usage by the newly insured.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E058**

Topic: SAVINGS FOR THE PUBLIC HOSPITAL SYSTEM

Written Question on Notice

Senator Evans asked:

(a) The Minister claims that the rebate will reduce the number of people in public hospitals by 500,000 patients a year. What are the assumptions used in arriving at this figure and on what research is it based?

(b) Given that the rebate has now been in place for over 18 months, what evidence does the Department have to show that the increase in private health insurance membership has reduced the number of patients in public hospitals?

Answer:

(a) The following methodology has been used to calculate the number of additional privately insured hospital episodes arising from the increase in private health insurance membership since December 1998.

In the first step quarterly age/sex specific hospital utilisation rates were derived by dividing the number of hospital episodes for each age/sex cohort in the December 1998 quarter by the number of people in each cohort holding insurance at the end of the quarter.

(This quarter was chosen as the last before the rate increased, and thus reflects underlying utilisation rates unaffected by new members serving waiting periods for pre-existing ailments. However, utilisation rates in the December quarter have historically been somewhat lower than the annual average, and this may lead to some conservative bias in the estimates.)

In the second step the number of additional members in each age/sex cohort was calculated by subtracting the December 1998 membership from the September 2000 membership.

The age/sex specific hospital utilisation rates were then applied to the additional members to calculate the additional quarterly episodes likely to flow from the increased membership (157,527).

This was annualised by multiplying by four (630,107), and then discounted by 10% to reflect actuarial advice on likely usage by the newly insured after three years (567,096).

This was rounded down to 550,000 for use in public statements.

(b) The stated aim of the 30% rebate has been to reduce pressure on public hospitals, not to reduce the number of patients in them.

Latest figures from the Private Health Insurance Administration Council show the following increases in privately insured episodes for the December 1999 to September 2000 quarters relative to the corresponding quarter in the previous year.

Quarters compared	**Increase in privately insured episodes**
December 1999 over December 1998	4%
March 2000 over March 1999	3%
June 2000 over June 1999	10%
September 2000 over September 1999	14%

The majority of these additional private episodes occurred in private hospitals. This suggests the resources in public hospitals which would have been used for these patients were freed up, thus allowing public hospitals to provide care for others on the public patient waiting list. Whether this actually happened is a matter for State Governments as managers of the public hospital system.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E066**

Topic: OUTSOURCING CONTRACT WITH IBM GSA

Hansard Page: CA 87

Senator Lundy asked:

> **You said there were no substantial changes [to specifications to the outsourcing contract with IBM GSA]. Can you describe perhaps the changes that did occur?**

Answer:

The substantive changes to the specifications were as follows.

- The lease of the Data Centre was removed as a condition precedent to the Contract.
- The notion of compensation for the removal from the Services of a "major segment" of the HIC's business was introduced.
- Benchmarking provisions were changed to allow for the release of information to other Agencies and Parliament. The HIC agreed to pay the costs of any benchmarking for the purpose of retaining control over the process.
- A Transition of Business clause was added to protect the Agencies in the wake of recent court cases.
- The Y2K clause had to be re-written due to slippage in contract signing dates.
- A clause allowing for expert determination in matters of fact relating to performance or non-performance was introduced, as was a mitigation clause.
- A new clause allowing the Contractor to verify billing units, acquired equipment, service contracts, software licences and work in progress was introduced.
- An Independent Event Report was introduced which allows the HIC to withhold 20% of invoiced charges pending adequate clarification of any issues that resulted in degradation of performance where service levels have not been meet.

- End to end reporting: the RFT required that 95% of entries have a 3 second response time from Medicare offices to the mainframe and back. This requirement was removed as it would have required IBM-GSA to provide data telecommunications carriage, at an additional cost to the HIC of $3.1 million per annum. This is because IBM-GSA is not entitled to the Office of Government Online discounts available to the HIC. As the HIC did not have guaranteed service levels prior to the RFT, the additional cost was not determined to be cost effective.

- Introduction of the Incentive Bonus Scheme: where prolonged periods of service over and above what is contracted is achieved, IBM-GSA is able to either offset any service credits and/or receive a bonus for the increased service provided. The service credit cap was reduced from 25% of fees to 20%.

- Call pick up times were extended to include an Interactive Voice Recognition (IVR) system. The RFT stated that calls were to be picked up by a help desk operator within 30 seconds. IBM-GSA requested that an IVR be used at the 15 second mark and at an additional 30 seconds from the IVR to pick up by a help desk operator. The impact was to add 15 seconds to the maximum time allowable before a help desk operator was to answer the call, but to introduce a message within 15 seconds to the caller.

- In addition, there were a number of changes of a non-substantive nature.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E086**

Topic: MEDICARE SPENDING

Written question on notice

Senator Evans asked:

What is the growth rate in Medicare spending provided for in the forward estimates and what growth rates in demand and rebate levels has been assumed for each major category of services?

Answer:

The growth rates in Medicare benefits expenditure in the forward estimates are:

Year	Growth
2000/01	3.40%
2001/02	4.05%
2002/03	4.47%
2003/04	4.58%

The growth rates in number of services for each major category of service are:

Major	Annual Growth Rate in Number of Services			
Category	**00-01**	**01-02**	**02-03**	**03-04**
Unreferred Attend	-0.36%	0.32%	0.63%	0.43%
Spec Attend	1.62%	1.68%	1.73%	1.62%
Obstetrics	-2.57%	-3.99%	-4.22%	-4.69%
Anaesthetics	1.86%	1.94%	2.23%	2.13%
Pathology	4.04%	4.87%	3.88%	3.88%
Diag Imaging	0.00%	2.61%	3.40%	3.17%
Operations	1.11%	1.80%	1.86%	1.76%
Optometry	2.70%	3.32%	3.28%	3.25%
Other MBS	3.99%	4.05%	3.94%	3.78%
Total MBS	1.10%	1.89%	2.02%	2.11%

The growth rates in rebate levels (as measured by average benefit per service) for each major category of service are:

Major	**Annual Growth Rate in Number of Services**			
Category	**00-01**	**01-02**	**02-03**	**03-04**
Unreferred Attend	4.88%	3.28%	3.28%	3.21%
Spec Attend	1.11%	1.21%	1.67%	1.87%
Obstetrics	5.03%	5.18%	5.67%	5.91%
Anaesthetics	1.78%	1.90%	2.35%	2.56%
Pathology	0.05%	1.10%	1.08%	1.08%
Diag Imaging	1.26%	1.90%	1.81%	1.78%
Operations	2.00%	2.13%	2.59%	2.80%
Optometry	1.03%	1.13%	1.59%	1.80%
Other MBS	2.40%	2.44%	2.89%	3.09%
Total MBS	2.27%	2.12%	2.40%	2.42%

The growth rates in average benefit per service include increases in benefit levels from annual indexation and fee drift (higher growth rates for the more expensive services).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E095**

Topic: Migrant parents

Written question on notice

Senator Crowley asked:

(a) Can you reconcile the Department's estimate of the $120,000 cost over 20 years with the $200,000 cost advised to Parliament by the Minister for Immigration and Ethnic Affairs on 31st October 2000?

(b) For a person with private health insurance what proportion of the $2,575 in hospital costs would be met by a private health fund if the person was treated as a private patient in a public hospital?

(c) What is the "some element of the medical costs" that would be met by private health insurance? Does this include any of the $750 in utilisation of Medicare that you are using as an average?

(d) Is it not the case that if a person had private health insurance under a ten year policy as wanted by the Government there would be no savings in Medicare, PBS or aged care costs and none in hospital costs if the person elected to be treated as a public patient?

(e) Can the Department provide any research it has on the variation in health costs for migrants and the average life expectancy after arrival in Australia in accordance with the discussion at Senate Estimates?

Answer:

(a) Hansard of 31 October 2000 indicates that the Minister for Immigration and Multicultural Affairs stated in his answer to Mrs Gallus "[i]t is estimated that, on average, each aged parent will incur about $6,000 a year in health costs and that more than half will make claims on our welfare system. It is further estimated that, on average, aged parents, after arrival in Australia, will live for a further 20 years. So, conservatively, it is estimated that each parent can incur costs of at least $200,000 over his or her lifetime."

The Minister appears to have combined health and welfare costs to reach a total of $200,000. He used the figure of $6000 a year for health care costs. This is consistent with the Department's estimate of $120,000 over 20 years.

(b) Where a person has private health insurance elements of the hospital costs which such insurance might meet include:

- 25 per cent of the schedule fee for professional services provided in hospital; and
- hospital accommodation costs.

(c) Where a person has private health insurance elements of the medical costs which such insurance might meet include:

- 25 per cent of the schedule fee for professional services provided in hospital; and
- hospital accommodation costs.

These costs would not be included in the $750 per annum average Medicare utilisation of the over-65 population. These average costs are for out-of-hospital services (eg GP consultations, diagnostic imaging, pathology).

(d) As part of the package of measures included in the Migration Legislation Amendment (Parents and Other Measures) Bill 2000 the Government included a proposal for a new class of parent visa. Under this new class applicants could take out 10 years of private health insurance as part of the meeting the conditions for the visa. This visa would be a permanent resident visa. Under the *Health Insurance Act 1973* permanent residents are eligible for Medicare benefits.

Were such a migrant parent to have taken out the private insurance but elected to be treated as a public patient he or she would have been exercising a choice available to all Australian citizens or permanent residents. As a public patient, there should not be any costs against Medicare or PBS associated with the person's in-hospital care. Private health insurance products offered by health benefits organisations are specifically precluded from offering insurance for residential aged care. Costs for a public patient's in-hospital care would be met by State/Territory funding for health care and moneys paid by the Commonwealth to the States and Territories through the Australian Health Care Agreements. Had the parent elected to be a private patient then he/she could have used private health insurance to meet accommodation fees charged by the public hospital.

(e) The Department does not currently have any research available on the variation in health costs for migrants and their average life expectancy after arrival in Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E001**

Topic: TERTIARY HOSPITALS WITHOUT MRI

Hansard Page: 10

Senator West asked:

> **Do we have any idea how many tertiary hospitals there are at present who do not have MRI's?**

Answer:

> There is no commonly accepted definition of what constitutes a 'tertiary hospital'. Nonetheless, it is generally accepted that tertiary hospitals have a major academic focus and provide a wide range of specialist services. Given the lack of clear definition, it is not possible to precisely state the exact number of such hospitals. The best estimate currently available to the Department is that there are approximately eleven such hospitals, which do not have an eligible MRI unit.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E149**

Topic: REPORT AND RECOMMENDATIONS OF THE COMMONWEALTH REVIEW OF POSITRON EMISSION TOMOGRAPHY (PET).

Hansard Page: CA 15/CA17

Senator West asked:

(a) Is it possible to have a copy of that report?

(b) The Department offered to provide the committee with a list of clinical PET indications recommended by the review for restricted funding.

Answer

(a) A preprint copy of the *Report of the Commonwealth review of positron emission tomography* is attached (Attachment A). The report is currently being edited for publication.

(b) The list is attached (Attachment B) and is also included in the report in Chapter 2, *Findings and recommendations* (pp. 8–9).

Note: Attachment A - report of the Commonwealth review of positron emission tomography not included in this volume

Commonwealth review of positron emission tomography: Clinical indications recommended for restricted funding

While the Steering Committee agrees that unrestricted funding is unwarranted at this time, the evidence suggests that PET is safe, potentially clinically effective and potentially cost effective in the indications reviewed. On this basis the Steering Committee recommends that FDG PET be funded on an interim basis for the following clinical conditions:

Differentiation of malignant from benign lesions in patients with a solitary pulmonary nodule
Currently, there is evidence only that FDG PET has sufficiently high accuracy and provides sufficient impact to justify its clinical use for differentiation of benign from malignant lesions in the case of isolated lung nodules.

Even for this indication, it is recommended that funding for FDG PET be limited to evaluation of lesions considered to be unsuitable for transthoracic fine needle aspiration (FNA) biopsy (due to severe lung disease or location of the lesion) or which have failed pathological characterisation.

Primary staging in patients with non- small cell lung cancer
On currently available evidence, it is recommended that funding for FDG PET be made available for the staging of patients with non-small cell lung cancer prior to surgery or radiotherapy with curative intent.

Primary staging in patients with suspected primary brain tumour
It is recommended that funding for FDG PET be made available to guide biopsy to the highest area of activity in primary brain tumour. (While the role of PET in this indication was not specifically evaluated, the MSAC Supporting Committee highlighted the potential value of PET in this area, which is seen to be an important clinical issue that warrants interim funding).

Evaluation of residual structural lesions after definitive therapy for colorectal cancer
It is recommended that funding be made available for FDG PET for the evaluation of residual structural abnormalities on diagnostic imaging in patients who are symptomatic following definitive therapy for colorectal cancer.

Evaluation of residual structural lesions after definitive therapy for recurrent glioma
It is recommended that funding for FDG PET be made available for the differentiation of radiation necrosis from recurrent glioma in patients treated with radiotherapy, who have residual structural abnormality on diagnostic imaging.

Pre-operative assessment of metastatic disease in colorectal cancer
It is recommended that funding for FDG PET be made available for pre-operative evaluation of patients being considered for surgical resection of hepatic or lung metastases from colorectal cancer.

Pre-operative assessment of apparently limited metastatic disease in malignant melanoma

It is recommended that funding for FDG PET be made available for pre-operative evaluation of patients being considered for surgical resection of apparently limited metastatic disease from malignant melanoma.

Localisation of epilepsy
It is recommended that funding for FDG PET be made available for the evaluation of a patient with refractory epilepsy who is being considered for surgery in a comprehensive epilepsy program, where there is inconclusive localising information on standard assessment, including seizure semiology, EEG and MRI.

Assessment of ischaemic heart disease
It is recommended that funding for FDG PET be made available for studies in patients with ischaemic heart disease and impaired left ventricular function and negative standard viability assessments if suitable for revascularisation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E002**

Topic: POSITRON EMISSION TOMOGRAPHY (PET) MACHINES

Hansard Page: CA 16

Senator West asked:

When did it [the recommendation on PET machines] go to the Minister?

Answer:

The report and recommendations of the review were forwarded to the Minister on 16 August 2000. The Minister agreed to the implementation of all recommendations on 31 August 2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E003**

Topic: NATIONAL HEALTH DEVELOPMENT FUND PROJECTS

Hansard Page: CA 23

Senator Evans asked:

What about the national health development projects and the state plans for those? Have they been developed?

Answer

National Health Development Fund (NHDF) strategic plans have been agreed between the Commonwealth and the relevant State/Territory health ministers for:

- New South Wales;
- Victoria;
- Queensland; and
- Northern Territory.

Tasmania's strategic plan is currently being finalised.

Other States and Territories are aware of their responsibility to develop a NHDF strategic plan and have advised the Commonwealth that they are doing so.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E004**

Topic: NATIONAL HEALTH DEVELOPMENT FUND

Hansard Page: CA 24

Senator Evans asked:

(a) Perhaps you could take it on notice as to whether or not you are going to make them (NHDF plans) available.

(b) How much of the money set aside for national health development projects has been spent? Perhaps you could take on notice how much has been spent (under the NHDF) and to what it has been applied.

Answer

(a) The Department has written to each of the States and Territories with approved NHDF strategic plans asking if they would agree to the Commonwealth passing on copies of their plans to the Committee.

(b) NHDF payments to States and Territories with approved strategic plans are based on payment schedules approved as part of the plan. To 30 November 2000, payments to those States and Territories are as follows:

State	Total NHDF allocation	Total payments to 30 November 2000*
New South Wales	86,000,000	19,445,835
Victoria^	63,000,000	24,425,935
Queensland	45,000,000	24,881,625
Western Australia	23,000,000	Nil
South Australia	21,000,000	Nil
Tasmania	6,500,000	Nil
Australian Capital Territory	6,400,000	Nil
Northern Territory	1,900,000	1,900,000

* Total payments include payments made in previous financial years.

^ The Commonwealth is currently seeking advice from the Victorian Department of Human Services regarding a revised payments schedule further to their intention to review aspects of their State's strategic plan.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E005**

Topic: NATIONAL HEALTH DEVELOPMENT FUND STRATEGIC PLANS

Hansard Page: CA 28

Senator West asked:

Is the department able to table these (AHCA) acquittal forms?

Answer

Copies of acquittal forms for the 1998-99 and 1999-2000 financial years are attached.

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by New South Wales under the terms of the Agreement in 1999/2000 as Health Care Grants:

BASE GRANT	$
General Component	1,928,164,279
Mental Health	17,210,379
Palliative Care	9,933,832
Quality Improvement	35,477,972
Total Base Grant	1,990,786,462
ADJUSTMENTS	8,768,818
TOTAL HEALTH CARE GRANT	1,999,555,280

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

T Reeson	Acting Director, Financial Management & Planning	13/10/00
Signature	Designation	Date

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amounts were received by New South Wales in 1999/2000 from the National Health Development Fund.

$ NIL /

[signature]	Acting Director, Financial Management + Planning	13/10/00
Signature	Designation:	Date

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by New South Wales under the terms of the Agreement in 1998/1999 as Health Care Grants:

BASE GRANT	$
General Component	1,810,178,025
Mental Health	16,682,775
Palliative Care	9,629,299
Quality Improvement	25,792,765
Total Base Grant	1,862,282,864
ADJUSTMENTS	42,220,538
TOTAL HEALTH CARE GRANT	1,904,503,402

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

Signature	Designation	Date
	Acting Director, Financial Management & Planning	5/5/00

AHCA.acq

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amounts were received by New South Wales in 1998/1999 from the National Health Development Fund.

$ NIL

	Acting Director, Financial Management & Planning	5/5/00
Signature	Designation	Date

AHCA.acq

Attachment 1

Department of Human Services - Victoria

AUSTRALIAN HEALTH CARE AGREEMENT

(1) Receipts 1998/99

	Receipts 1998/99
Health Care Grants	$1,366,005,452
National Health Development Fund	0
Total	$1,366,005,452

I certify that this statement agrees with the Department's accounting records.

Signature: Date: 24 Nov 1999

Name: Nicholas Scott

Position: Acting Assistant Director, Financial and Administrative Services, Department of Human Services, Victoria

(2) I certify that all funds were received and have been applied to the agreed purposes in the Australian Health Care Agreement

Signature: Date: 24/11/99

Name: Chris Brook

Position: Director, Acute Health Services, Department of Human Services, Victoria

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by ... Queensland Health ... under the terms of the Agreement in ... 1998/ 1999 ... as Health Care Grants:

BASE GRANT	
General Component	$ ... 966, 170, 869 ...
Mental Health	$ ... 9, 35, 976 ...
Palliative Care	$ ... 5,045,797 ...
Quality Improvement	$ ... 13, 515, 527 ...
Total Base Grant	$ 993, 868, 169
ADJUSTMENTS*	$ ... 50, 607, 000 ...
TOTAL HEALTH CARE GRANT	$ 1,054,475,169

* Positive amounts should be reported separately.
* Negative amounts should be reported as an adjustment to the General Component of Base Health Care Grants.

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

Signature	Manager Finance Unit	2/3/2000
	Designation	Date

Health and
Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amount was received by Queensland Health
in 1998 / 1999 from the National Health Development Fund.

$ Nil

Paul Monaghan	~~Manager~~ Finance Unit	2/3/2000
Signature	Designation	Date

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by the Health Department of WA under the terms of the Agreement in 1999 /2000 as Health Care Grants:

BASE GRANT	
General Component	$544,361,872.00
Mental Health	$4,995,922.00
Palliative Care	$2,692,695.00
Quality Improvement	$9,616,769.00
Total Base Grant	$561,668,259.00
ADJUSTMENTS*	$8,000,000.00
TOTAL HEALTH CARE GRANT	$569,668,259.00

* An amount of $2,400,000 was forwarded to the Office of Seniors, as part of the Commonwealths contribution to the Gerontology Institute Of Western Australia.

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

		A/General Manager, Finance & Resource Management	21/8/00
Signature Mr Alex Kirkwood		Designation	Date

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amount was received by the Health Department of WA in 1999/2000 from the National Health Development Fund.

$ Nil

Signature Mr Alex Kirkwood	A/General Manager, Finance & Resource Management Designation	21/8/00 Date

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by the Health Department of WA under the terms of the Agreement in 1998 /1999 as Health Care Grants:

BASE GRANT	
General Component	$507,494,264.00
Mental Health	$4,818,197.00
Palliative Care	$2,596,386.00
Quality Improvement	$6,954,605.00
Total Base Grant	$521,863,452.00
ADJUSTMENTS*	$47,735,475.00
TOTAL HEALTH CARE GRANT	$569,598,927.00

* Positive amounts should be reported separately.
* Negative amounts should be reported as an adjustment to the General Component of Base Health Care Grants.

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

		A/General Manager, Finance & Resource Management	24/3/00
Signature Mr Alex Kirkwood		Designation	Date

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amount was received by the Health Department of WA in 1998 /1999 from the National Health Development Fund.

$ Nil

	A/General Manager, Finance & Resource Management	25/3/00
Signature Mr Alex Kirkwood	Designation	Date

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by ACT Government under the terms of the Agreement in 1998/99 as Health Care Grants:

BASE GRANT	
General Component	$ 65,034,327
Mental Health	$ 1,000,000
Palliative Care	$ 399,180
Quality Improvement	$ 1,071,374
Total Base Grant	$ 67,505,681
ADJUSTMENTS*	$ 3,553,862
TOTAL HEALTH CARE GRANT	$ 71,059,543
— LESS NATIONALLY FUNDED CENTRES	— 112,193
	70,947,350

* Positive amounts should be reported separately.
* Negative amounts should be reported as an adjustment to the General Component of Base Health Care Grants.

2) the Health Care Grant funding received was expended on the provision of public hospitals services. Note that some funds were rolled over into the following year for specific expenditure initiatives.

Signature	Designation	Date
	Executive Director	3/5/2000

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amount was received by ACT Government in 1998 / 99 from the National Health Development Fund.

$ Nil

Signature	Designation	Date
	Executive Director	28-4-2000

Commonwealth Department of Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by TERRITORY HEALTH SERVICES under the terms of the Agreement in 1998/99 as Health Care Grants:

BASE GRANT	
General Component	$ 58 973 144
Mental Health	$ 1 000 000
Palliative Care	$ 620 000
Quality Improvement	$ 556 024
Total Base Grant	$ 61 129 168
ADJUSTMENTS*	$ 20 144 002
less NFC Contribution	(58 226)
TOTAL HEALTH CARE GRANT	$ 81 214 944

* Positive amounts should be reported separately.
* Negative amounts should be reported as an adjustment to the General Component of Base Health Care Grants.

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

Signature	Designation	Date
	ACTING MANAGER BUDGET SERVICES	12 APRIL 2000

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

HEALTH CARE GRANT

Certificate pursuant to Clause 23 of Schedule E

I certify that:

1) the following amounts were received by TERRITORY HEALTH SERVICES under the terms of the Agreement in 1998/99 as Health Care Grants:

BASE GRANT	
General Component	$ 58 973 144
Mental Health	$ 1 000 000
Palliative Care	$ 620 000
Quality Improvement	$ 556 024
Total Base Grant	$ 61 129 168
ADJUSTMENTS*	$ 20 144 002
less NFC Contribution	(58 226)
TOTAL HEALTH CARE GRANT	$ 81 214 944

* Positive amounts should be reported separately.
* Negative amounts should be reported as an adjustment to the General Component of Base Health Care Grants.

2) the Health Care Grant funding received was expended on the provision of public hospitals services.

Signature	Designation	Date
	ACTING MANAGER BUDGET SERVICES	12 APRIL 2000

Health and Aged Care

AUSTRALIAN HEALTH CARE AGREEMENT

NATIONAL HEALTH DEVELOPMENT FUND

Certificate pursuant to Clause 23 of Schedule E

I certify that:

the following amount was received by TERRITORY HEALTH SERVICES in 1998/99 from the National Health Development Fund.

$ Ø

[signature]	ACTING MANAGER BUDGET SERVICES	14 APRIL 2000
Signature	Designation	Date

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 2: ACCESS TO MEDICARE **Question: E065**

Topic: REFERRALS FROM CUSTOMS

Hansard Page: CA 27

Senator West asked:

> **Yes, that was the sort of figure I was after – how many referrals you get from Customs a day, a week, a month or a year [in relation to the interception of PBS drugs taken out of the country]. You are saying a couple of dozen a year.**

Answer:

A more precise figure would be 18 per year.

MRI Monitoring and Evaluation Group

Terms of Reference

- review MRI utilisation data each month
- advise on the location of new MRI sites
- advise on the number of scans required each year
- manage the proposed pilot study on general practitioner (GP) referral issues and substitution
- oversee work on establishing a differential fee structure for MRI
- oversee the work associated with the proposed review of MRI and computed tomography costs and Schedule fees
- undertake further work on the recommendations relating to the location of additional eligible MRI units and interim funding arrangements for MRI services

Membership of the Group

- people with expertise in radiology
- a representative from the Department (Dr Louise Morauta)
- a representative of the HIC (Mr Geoff Leeper)
- a representative of State and Territory Government (AHMAC has been approached for nominees)
- a consumer representative (the Health Issues Centre of La Trobe University has been approached for nominee/s)
- a health economist (Professor Richard Scotton)
– Prof. John Blandford (Chair)

Tabled 22.11.00

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E055**

Topic: APPOINTMENT OF ADMINISTRATORS

Written Question on Notice

Senator Gibbs asked:

(a) What is the standard form of contract that the department uses when entering into an administration agreement with a provider in lieu of revocation of approved provider's approval under Part 2.1 of the Aged Care Act 1997?

(b) What are the key components in relation to provider obligations once the Department accepts administration of a facility under the Sanctions Principles of the Aged Care Principles 1997?

(c) Is the approved administrator an employee of the provider for the purposes of the administration agreement?

(d) What rights and/or obligations does the appointed administrator have to the provider in relation to the operation the facility during the period under administration? i.e. what powers under the Act does the administrator have to control the operation of the facility?

(e) What recourse does an appointed administrator have with the department if the 'contract' between themselves and the provider is frustrated by provider interference? Have administrators approached the Department over this issue?

(f) Is a copy of the contract of, or the agreement for, administration made available to the relevant personnel, including the nurse in charge of nursing services?

Answer:

(a) There is no such standard form of contract as the Secretary's role is to approve or refuse to approve the appointment under the Sanctions Principles, not to enter into an administration agreement.

(b) Provider obligations remain the same once the Secretary has either approved or refused the appointment of an administrator under the Sanctions Principles.

(c) An approved administrator acts for and on behalf of the approved provider.

(d) An administrator has no powers under the *Aged Care Act 1997* (the Act) to "control" the operation of a facility but, under recently agreed amendments to the Act, has certain rights to information and to manage a facility to ensure that care standards are met and maintained.

(e) Any contract between the approved provider and an administrator is a matter for those parties, subject to the response provided in relation to (d) above.

(f) This is not known.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E056**

Topic: APPOINTMENT OF ADMINISTRATORS STAFFING

Written Question on Notice

Senator Gibbs asked:

(a) What provisions are contained within an agreement or contract of administration of an aged care facility to prevent reduction in staff numbers, skills mix and care hours following accreditation of the facility? and

(b) Does the Department or the Standards and Accreditation Agency have a requirement, in the interests of monitoring continuous improvement strategies of a residential aged care facility, for facilities to notify staffing and key personnel changes following accreditation?

Answer:

(a) Accreditation is conditional on ongoing compliance with the Accreditation Standards and other obligations under the *Aged Care Act 1997* (the Act). The Agency continues to supervise an accredited service through support contacts, and if the Agency has reason to believe that there may not be compliance, a review audit may be conducted. Depending on the results of the review audit, the Agency may make a decision to require improvements, vary the period of accreditation or revoke the accreditation.

(b) Approved providers are obliged, under Section 9-1 of the Act, to notify the Secretary of changes to key personnel, within 28 days after the change occurs. The Department informs the Aged Care Standards and Accreditation Agency of such changes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E094**

Topic: APPOINTMENT OF ADMINISTRATORS

Written Question on Notice

Senator Evans asked:

Is the Department involved in setting the terms upon which administrators are appointed under Division 66-2 i.e. is there a standard form of contract or other set of terms that the Department insists in these circumstances?

Answer:

No

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E087**

Topic: ALLOCATION ROUND

Written Question On Notice

Senator Evans asked:

In respect of the allocation round

(a) How many applications for residential aged care places were received for the allocation round?

(b) Can the Department provide a breakdown on the number of places applied for in each State/Territory, specifying high care, low care and community care places?

(c) Can the Department provide information on the applications, i.e. the number and types of places applied for in each region, for the following providers: Moran Health Care (Australia) Pty Ltd and Moran Health Care Group (Victoria) Pty Ltd.

Answer:

(a) A total of 943 applications for residential aged care places and 1,119 for Community Aged Care Packages were received for the 2000 Aged Care Approvals Round.

(b) Details of the number of places are in the coordinated round application booklet. There was a strong response to the round with multiple applications received in most targeted regions.

(c) The information requested is protected information under Division 86 of the Aged Care Act 1997 (the Act).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E088**

Topic: AGED CARE POPULATION ESTIMATES

Written Question on Notice

Senator Evans asked on 22 November 2000:

(a) Can the Department provide the latest estimates of the population aged 70 and over in each planning region?

(b) Can the Department provide the latest estimates of the populations aged 70 and over in each Federal electorate? (the Department's electorate profiles use the original census data from 1996)

Answer:

(a) Attachment 1 provides a breakdown of population by Aged Care Planning Region based upon Australian Bureau of Statistics population projections for the 70 and over age group as at 30 June 2000.

(b) Planning is done on the basis of Aged Care planning regions not electorates.

Attachment 1 **Question E088**

State	Aged Care Planning Regions	ABS population projections of 70+ for 30 June 2000
NSW	Central Coast	37,846
	Central West	16,018
	Far North Coast	30,908
	Hunter	54,564
	Illawarra	40,410
	Inner West	39,701
	Mid North Coast	34,292
	Nepean	18,439
	New England	16,170
	Northern Sydney	80,401
	Orana Far West	13,153
	Riverina/Murray	26,145
	South East Sydney	78,445
	South West Sydney	46,248
	Southern Highlands	15,718
	Western Sydney	44,216
	NSW Total	**592,674**
Vic	Barwon-South Western	36,604
	Eastern Metro	86,828
	Gippsland	24,522
	Grampians	20,682
	Hume	23,411
	Loddon-Mallee	29,294
	Northern Metro	60,197
	Southern Metro	108,763
	Western Metro	42,326
	Vic Total	**432,627**
Qld	Brisbane North	39,172
	Brisbane South	49,522
	Cabool	20,915
	Central West	955
	Darling Downs	19,798
	Far North	13,232
	Fitzroy	11,980
	Logan River Valley	11,361
	Mackay	7,090
	North West	1,300
	Northern	13,539
	South Coast	36,629
	South West	1,929
	Sunshine Coast	28,002
	West Moreton	10,703
	Wide Bay	20,473
	Qld Total	**286,600**

SA	Eyre Peninsula	3,213
	Hills, Mallee & Southern	11,552
	Metropolitan East	33,564
	Metropolitan North	19,318
	Metropolitan South	35,589
	Metropolitan West	29,271
	Mid North	3,559
	Riverland	3,604
	South East	5,948
	Whyalla, Flinders & Far North	3,404
	Yorke, Lower North & Barossa	9,147
	SA Total	**158,169**
WA	Goldfields	2,059
	Great Southern	6,081
	Kimberley	869
	Metropolitan East	29,324
	Metropolitan North	40,746
	Metropolitan South	36,407
	Mid West	3,665
	Midlands	3,983
	Pilbara	642
	South West	16,051
	WA Total	**139,827**
Tas	North Western	9,878
	Northern	13,154
	Southern	21,620
	Tas Total	**44,652**
NT	Alice Springs	751
	Barkly	122
	Darwin	2,577
	East Arnhem	127
	Katherine	275
	NT Total	**3,852**
ACT	ACT	17,407
Australia		**1,675,808**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E089**

Topic: INTERNATIONAL YEAR OF OLDER PERSONS

Written Question on Notice

Senator Evans asked:

(a) Having provided the initial survey, can the Department provide the reports/findings on the surveys of community attitudes conducted during and after the IYOP?

(b) Will further surveys be conducted to ensure that any impact on community attitudes is sustained?

Answer:

(a) Copies of the reports on the outcome of initial surveys of community attitudes conducted by Worthington Di Marzio were provided to you in June 1999. A copy of the report of research conducted in early 2000 was provided to you in June 2000.

(b) The Department plans to continue to monitor community attitudes and to conduct further surveys periodically. Further surveys for departmental use may be conducted on a needs basis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E090**

Topic: SURPRISE INSPECTIONS AND REVIEW AUDITS

Written Question on Notice

Senator Evans asked:

(a) What is the total number of surprise inspections conducted to date in each State/Territory?

(b) Can the Agency confirm how many full review audits were conducted in each State/Territory in 1998-99 and 1999-2000 (separately identified)?

(c) Can the Agency confirm that a report is published on every such review audit and therefore these totals can be easily derived by totalling the number of reports published over these periods?

Answer:

(a)

STATE	**No. of spot checks as at 19 Nov 2000**
NSW & ACT	15
QUEENSLAND	26
VICTORIA	174
SA & NT	15
TASMANIA	2
WESTERN AUSTRALIA	17
TOTAL	**249**

(b) The number of full assessments, conducted under the former Accreditation Grant Principles, for the period financial year 1998-99 was 210. The number of full assessments, conducted under the former Accreditation Grant Principles, plus the number of review audits, conducted under the current Accreditation Grant Principles, for the period financial year 1999-00 was 123. Only national figures are available.

(c) Reports are not published for all review audits, for example, review audits of accredited services. However these are available on request.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E091**

Topic: PROTECTED INFORMATION

Written Question on Notice

Senator Evans asked:

(a) Can the Department explain who determines whether information is protected under the Aged Care Act and on what grounds that decision is made?

(b) Can the Department explain why information on the number of hospital leave days accessed by residents in certain nursing homes is protected?

(c) Can the Department explain why it now considers the dates on which complaints against a certain nursing home were lodged are protected, when this information was provided previously in relation to the Chelsea Nursing Home?

Answer:

(a) "Protected information" is a category of information legally defined in the *Aged Care Act 1997* (the Act).

Protected information is information that was acquired under or for the purposes of the Act and either is personal information or relates to the affairs of:

- an approved provider;
- an applicant for approval under Part 2.1 of the Act; and
- an applicant for a grant under Chapter 5 of the Act.

(b) All personal information about residents held by the Department is protected information under the Act, including the number of days of hospital leave accessed by any resident.

(c) Given the above definition, the dates on which complaints were made against a certain nursing home fits into the above category.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E092**

Topic: ACCREDITATION

Written Question on Notice

Senator Evans asked:

(a) Can the Agency provide figures on the number of facilities visited, granted 3-year accreditation, 1-year accreditation and that failed accreditation in each State/Territory?

(b) How many accreditations have been revoked or downgraded in each State/Territory?

Answer:

(a)

As at 17 November 2000	NSW & ACT	QLD	VICTORIA	SA & NT	TAS	WA
No. of services accredited for 3-years	891	292	642	294	95	239
No. of services accredited for 1-year	17	16	35	15	1	16
No. of services accredited for a period other than 1 or 3 years	1	0	4	1	1	1
No. of services with not to accredit decisions	2	4	16	6	0	3
No. of site audits	954	481	832	322	99	269

(b) As at 17 November 2000, two services have had their accreditation revoked following review audits. Both services had their accreditation reinstated following reconsideration, however, for a lesser period than was originally granted. As at 17 November 2000, four services had their period of accreditation varied to a lesser period, following review audits.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E074**

Topic: ACCREDITATION

Hansard page: CA55

Senator Denman asked:

I have a question on accreditation which has caused a lot of concern where I live on the north-west coast of Tasmania. A nursing home called Umina Park has had its accreditation dropped from three years to two years. Can you tell me about that case? I have had a lot of concerned family members phone me.

Can you get to me the detail of why the accreditation dropped from three to two years?

Answer:

Umina Park High Care was awarded three-years accreditation on 15 February 2000.

Following a referral from the Secretary, Department of Health and Aged Care, a review audit was conduced on 29, 30 August and 5 September 2000. The audit identified that expected outcome 4.4 "Living Environment", was non-compliant as the service's restraint practices presented serious risk to residents. The approved provider and the Secretary, Department of Health and Aged Care, were notified. The Agency State Manager, Victoria and Tasmania, made a decision to vary the period of accreditation, from three years to two years, effective 15 September 2000.

The Agency State Manager, Victoria and Tasmania, met with the Board of Umina Park High Care and the Department of Health and Aged Care, and an appropriate action plan was received from the service. A support visit conducted on 24 October 2000 found that improvements were being implemented. Further support contacts have taken place and are scheduled. The service did not seek reconsideration of the decision.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E093**

Topic: ACCOMMODATION CHARGES AND CONCESSIONAL RESIDENTIAL SUPPLEMENT

Written Question on Notice

Senator Evans asked:

(a) Can the Department indicate which residential aged care facilities have closed down (i.e. bed licences transferred to another provider and the site no longer used as a nursing home/hostel) in the period 1 July 1998 to 27 November 2000?

(b) For each of these facilities can the Department indicate the total amount received through the concessional resident supplement?

(c) For each of these facilities can the Department indicate the number of residents who would have been required to pay the accommodation charge?

Answer:

Location details of residential aged care facilities which have closed in the period 1 July 1998 to 27 November 2000 and the total amount received through the concessional residential supplement for each of these facilities is contained in the table at Attachment 1.

The Department does not have details of the number of residents who would have been required to pay the accommodation charge. The accommodation charge is an arrangement between a service provider and resident.

Question: E093
Attachment 1

Residential Aged Care Facilities Closures

The table below shows details of those services which closed over the period 1/7/1998 to 27/11/2000 and the amount of concessional supplement paid to them.

Suburb	State	Postcode	Amount
Ballina	NSW	2478	$ 20,090.24
Balmain	NSW	2041	-
Belmore	NSW	2192	$ 98,743.11
Bondi	NSW	2026	-
Burradoo	NSW	2576	-
Burwood	NSW	2134	$ 43,294.41
Castle Hill	NSW	2154	$ 31,137.50
Collaroy	NSW	2097	-
Concord	NSW	2137	-
Coogee	NSW	2034	$ 18,302.15
Croydon	NSW	2132	$ 27,799.15
Culcairn	NSW	2660	-
Eastwood	NSW	2122	$ 28,374.95
Granville	NSW	2142	-
Harbord	NSW	2096	-
Homebush	NSW	2140	-
Hornsby	NSW	2077	$ 28,251.18
Hurlstone Park	NSW	2193	$ 37,392.17
Jamberoo	NSW	2533	-
Kensington	NSW	2033	$ 87,527.14
Kensington	NSW	2033	$117,315.94
Lismore	NSW	2480	$ 14,891.99
Manly	NSW	2095	-
Manly	NSW	2095	-
Marrickville	NSW	2204	-
Mosman	NSW	2088	$ 32,289.15
Randwick	NSW	2031	$ 1,700.81
Roseville	NSW	2069	$ 44,017.29
Springwood	NSW	2777	$ 2,300.92
Strathfield	NSW	2135	$ 4,938.66
Strathfield	NSW	2135	-
Summer Hill	NSW	2130	$ 36,735.08
Surry Hills	NSW	2010	$ 5,088.17
Tamworth	NSW	2340	$ 71,922.21
Trangie	NSW	2823	$ 9,024.09
Wagga Wagga	NSW	2650	$ 3,864.39
Wentworth Falls	NSW	2782	$ 28,416.26

Wentworth Falls	NSW	2782	-
Woolooware	NSW	2230	$ 45,261.17
Dudley	NSW	2290	-
Petersham	NSW	2049	-
Armadale	VIC	3143	-
Ascot Vale	VIC	3032	-
Bairnsdale	VIC	3875	-
Balaclava	VIC	3183	-
Ballarat	VIC	3350	$ 6,625.99
Ballarat	VIC	3350	-
Beulah	VIC	3395	-
Boronia	VIC	3155	-
Box Hill	VIC	3128	-
Brighton	VIC	3186	$ 48.68
Camberwell	VIC	3124	-
Carnegie	VIC	3163	-
Caulfield North	VIC	3161	-
Caulfield South	VIC	3162	-
Cheltenham	VIC	3192	-
Cheltenham	VIC	3192	-
Coburg	VIC	3058	-
Dandenong	VIC	3175	-
Dandenong	VIC	3175	-
Elsternwick	VIC	3185	$ 87,097.00
Essendon	VIC	3040	-
Ferntree Gully	VIC	3156	$ 47,034.71
Fitzroy	VIC	3065	-
Footscray	VIC	3011	-
Grovedale	VIC	3216	$ 34,980.25
Hamilton	VIC	3300	-
Ivanhoe	VIC	3079	-
Kew	VIC	3101	$ 2,761.40
Kew	VIC	3101	-
Kew	VIC	3101	-
Keysborough	VIC	3173	$ 41,914.69
Malvern	VIC	3144	$ 1,224.07
Malvern East	VIC	3145	-
Mildura	VIC	3500	-
Moe	VIC	3825	-
Moonee Ponds	VIC	3039	-
Mornington	VIC	3931	$ 9,075.89
Mornington	VIC	3931	$ 16,256.16
Murrumbeena	VIC	3163	$ 19,599.15
Newtown	VIC	3220	-
Northcote	VIC	3070	-
Oakleigh	VIC	3166	-
Parkville	VIC	3052	-
Patterson Lakes	VIC	3197	-

Prahran	VIC	3181	-
Robinvale	VIC	3549	$ 43,655.15
Sandringham	VIC	3191	$ 5,605.60
Sorrento	VIC	3943	-
St Kilda	VIC	3182	$ 10,194.97
St Kilda	VIC	3182	-
St Kilda East	VIC	3183	-
St Kilda East	VIC	3183	-
Surrey Hills	VIC	3127	-
Wangaratta	VIC	3677	$ 76,497.36
Warrnambool	VIC	3280	-
Warrnambool	VIC	3280	-
Wycheproof	VIC	3527	$ 22,023.53
Yarraville	VIC	3013	$ 66,206.23
Portland	VIC	3305	-
Bentleigh	VIC	3204	-
Charleville	QLD	4470	$ 11,600.23
Charleville	QLD	4470	$ 2,821.65
Fortitude Valley	QLD	4006	$ 12,381.76
Herston	QLD	4006	$124,559.31
Highgate Hill	QLD	4101	$ 25,985.81
Kedron	QLD	4031	-
North Mackay	QLD	4740	$ 5,689.52
Sandgate	QLD	4017	-
Southport	QLD	4215	$ 5,479.72
Toowoomba	QLD	4350	$ 3,942.33
East Brisbane	QLD	4169	-
Augusta	WA	6290	$ 5,780.75
Augusta	WA	6290	$ 6,827.37
Bayswater	WA	6053	-
Beverley	WA	6304	$ 4,054.99
Como	WA	6152	-
Denmark	WA	6333	-
Fremantle	WA	6160	$ 23,325.80
Kondinin	WA	6367	-
Kununurra	WA	6743	$ 3,152.44
Marangaroo	WA	6064	$ 29,122.20
Mount Lawley	WA	6050	$ 3,671.22
Spearwood	WA	6163	-
Spearwood	WA	6163	-
Subiaco	WA	6008	$ 2,618.50
Three Springs	WA	6519	$ 4,978.20
Wongan Hills	WA	6603	$ 10,132.14
York	WA	6302	-
Glenelg	SA	5045	$ 64,546.32
Glengowrie	SA	5044	$ 14,379.05
Glengowrie	SA	5044	$ 18,722.30
Goodwood	SA	5034	$ 7,886.10

Goodwood	SA	5034	$ 25,860.75
Hendon	SA	5014	$ 54,216.54
Hendon	SA	5014	$ 32,581.44
Hindmarsh	SA	5007	$194,349.19
Joslin	SA	5070	-
Kingscote	SA	5223	$ 4,445.06
Norwood	SA	5067	$ 87,905.71
Norwood	SA	5067	$ 26,054.35
Rose Park	SA	5067	$ 8,057.00
Rose Park	SA	5067	$ 3,478.90
Strathalbyn	SA	5255	$ 1,306.40
Strathalbyn	SA	5255	$ 4,391.30
Torrensville	SA	5031	$ 19,546.13
Unley	SA	5061	$ 3,995.61
Woodcroft	SA	5162	$ 22,096.80
Woodcroft	SA	5162	$ 17,738.71
Lindisfarne	TAS	7015	$ 54,693.50
New Town	TAS	7008	$ 13,447.23
New Town	TAS	7008	$ 348.00
Prospect Vale	TAS	7250	$ 85,356.13
Prospect Vale	TAS	7250	$ 27,419.87

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E112**

Topic: MEASURES FOR NURSING HOME BEDS

Written Question on Notice

Senator Denman asked:

(a) Are you satisfied the measures for nursing home beds, e.g. 100-1000 are adequate?

(b) Where do those measures come?

(c) How old are they?

(d) Do you feel that the measures need re-examining in terms of the structural changes in our society in the last decade, eg the increasing amount of people in the 70-80 age group, the changes in family relationships and the increasing likelihood of geographical separation of families all amounting to a sense that what may have been a fair indication of need met ten or twenty years ago may no longer be useful?

Answer:

(a) The current planning ratio of 100 places per 1000 population aged 70 and above is adequate.

(b) The planning ratio of 100 places per 1000 population aged 70 and above was adopted by Government in 1987 as providing a transparent index of growth in need for residential care. Use of the 70+ figure has resulted in a steady increase in provision of aged care in line with population ageing.

(c) See (b)

(d) See (b)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplement Budget Estimates 2000-2001, 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E073**

Topic: NURSING HOME CLOSURES

Hansard Page: CA 46

Senator Evans asked on 22 November 2000:

(a) In relation to nursing home closures are we able to say how many nursing homes have closed in the last three months?

(b) Do you have a more recent breakdown of those (from 30 August 2000)?

Answer:

(a) and (b)

In the period 31 August 2000 to 30 November 2000, 17 residential aged care facilities closed. Of these, 8 were relocated by the provider to new premises, 3 were sold to a new provider at different premises, 2 have been integrated into Multi-Purpose services, 3 are closed pending restructuring of the facility, and 1 is permanently closed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E075**

Topic: REVIEW AUDIT

Hansard page: CA55

Senator West asked:

Has the Albury and District Private Hospital had its visit in September? What was the result of that?

Answer:

Albury and District Private Nursing Home underwent its accreditation site audit from 10-12 October 2000. The facility received one year accreditation from 2 December 2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E076**

Topic: COMMISSIONER FOR COMPLAINTS

Hansard Page: CA 57

Senator Evans asked:

In relation to the Commissioner for Complaints staff: Is there a duty statement for those people? I just want to know what they are doing?

Answer:

Duties:

1. Support the Commissioner in the ongoing review and evaluation of the efficiency and effectiveness of the Commonwealth Complaints Resolution Scheme, including:
   - the regulatory framework;
   - protocols, processes within the Scheme.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E077**

Topic: COMMISSIONER OF COMPLAINTS – CONFIDENTIAL COMPLAINTS

Hansard Page: CA60

Senator Evans asked:

Mr Podger, perhaps you would take on notice for me the question about the complaints scheme and the commissioner accepting and acting on complaints – that is, where the person identifies themselves but does not want their name used. I think this is a huge issue in aged care, where nurses in particular, and other staff, are fearful of ongoing employment difficulties if they are identified but where they may raise some of the most serious concerns.

Answer:

Both the Complaints Resolution Scheme and the Commissioner for Complaints are able to accept confidential complaints.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2000-2001 22 November 2000

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS **Question: E078**

TOPIC: RESPITE CARE

Hansard Page: CA 61

Senator Gibbs asked:

From the data collected can you tell us about the carer contacts and assistance provided, say, in the last financial year? I would like to know how many inquiries were made and whether you can provide a breakdown of the main types of inquiries?

(a) How many carers were assisted to purchase respite care through the carer respite centres?

(b) What proportions of requests, say, for emergency respite and short-term respite were able to be met?

(c) Also, whether this respite was provided in community or residential facilities.

Answer

(a) In 1999/2000, 24,864 carers were assisted to purchase respite care by the Carer Respite Centres,

(b) All carers are offered emergency or short-term respite.

(c) In 1999/2000, 74 % of carers used community based respite while the remaining 26 % used residential respite.

Commonwealth Department of
Health and
Aged Care

OFFICE OF THE DEPUTY SECRETARY
GPO Box 9848 Canberra ACT 2601
Telephone: (02) 6289 8406 Fax: (02) 6285 1994
ABN 83 605 426 759

Senator Sue Knowles
Chairperson
Senate Committee on Community Affairs
Parliament House
CANBERRA ACT 2600

Dear Senator Knowles

I write to clarify a response I gave on Wednesday 22 November 2000, during Supplementary Budget Estimates 2000-2001 hearings before the Senate Community Affairs Legislation Committee in relation to Outcome 3 (Aged and Community Care) for the Department of Health and Aged Care.

During those Hearings I responded to a question asked by Senator Evans in relation to 75 Thames Street and the number of new complaints received by the Complaints Resolution Scheme between 2 June and 26 August 2000. I indicated that there were none, and said I had discussed this with the Assistant State Manager in Victoria recently. Both of these responses in my understanding, were true.

I have, however, now been advised that the Assistant State Manager did not realise that I was asking about new complaints in relation to that particular period of time. The information provided to me and that I subsequently relayed to Senator Evans, was in relation to a different time period.

In fact, between the period 2 June and 24 August the Department received three additional complaints.

I trust this clarifies the matter and accordingly, have attached an amended response.

Yours sincerely

Mary Murnane
Deputy Secretary

19 December 2000

[authorised for electronic transmission by Mary Murnane]

ORIGINAL TRANSCRIPT

Senator Evans:

"Was there any new information between 2 June and 24 August when that decision was made?

Ms Hefford:

Not that I am aware of.

Senator Evans:

There was no additional information between 2 June and 24 August when that decision was made?

Ms Hefford:

No

Senator Chris Evans:

I am still not clear why then on 24 August you made that decision. I know you had a watching brief. But if nothing else came in, why would it get a visit now?

Mr Podger:

I thought Ms Murnane answered that by saying that there was a reflection then of all outstanding complaints to see whether we needed to rethink the priorities. It thought that was the answer.

Senator Chris Evans:

I thought that happened much earlier in the year, Mr Podger.

Ms Murnane::

Senator, since that came up, I have myself spoken to our aged care branch manager in Victoria and specifically asked her if there were any further complaints and she said no. What we were doing progressively and methodically was tying up things that we had not been able to deal with and that we did not think the agency would be able to deal with in the light of more urgent and immediate priorities earlier on. If there had been any subsequent complaint from any source at all that we knew of, we would tell you now.

SUGGESTED AMENDMENT

Senator Evans:

"Was there any new information between 2 June and 24 August when that decision was made?

Ms Murnane:

The Department received three additional complaints during that period Senator.

3

17

Committee Amendment Principles 2000 (No. 1)

I, BRONWYN KATHLEEN BISHOP, Minister for Aged Care, make these Principles under section 96-1 of the *Aged Care Act 1997*.

Dated 31st August 2000

Bronwyn Bishop

Minister for Aged Care

1 Name of Principles

These Principles are the *Committee Amendment Principles 2000 (No. 1)*.

2 Commencement

These Principles commence on 31 August 2000.

3 Amendment of *Committee Principles 1997*

Schedule 1 amends the *Committee Principles 1997*.

TABLED 22.11.00

Schedule 1 Amendments

Do not delete: Schedule Part Placeholder

(section 3)

[1] Section 10.3, after definition of *Aged Care Principles*

insert

Commissioner for Complaints means the person appointed under section 10.77.

[2] Section 10.3, definition of *National chairperson*

omit

[3] Section 10.33

after

Complaints Resolutions Committees,

insert

and of the Commissioner for Complaints,

[4] Paragraph 10.34 (a)

omit

coordinate and

[5] After section 10.34

insert

10.34A Functions of Commissioner for Complaints

(1) In addition to chairing committees, the Commissioner's functions are:

(a) to supervise the chairpersons and other members of the Complaints Resolution Committees;

(b) to coordinate and review complaints received by the Secretary;

(c) to oversight the effectiveness of the Scheme;

(d) to deal with complaints about the operation of the Scheme;

(e) to manage the determination process, including the review of determinations;

(f) to promote an understanding of and acceptance of the Scheme;

(g) to advise the Minister on matters relevant to the operation of the Scheme.

(2) The Commissioner's functions also include the following:

(a) to give regular reports to the Secretary and the Minister about issues arising out of complaints dealt with under the Scheme;

(b) to annually review, and report to the Minister about, the operation of the Scheme.

[6] Subsection 10.71 (1)

omit

Secretary,

insert

Commissioner for Complaints,

[7] Subsections 10.71 (2) and (3)

substitute

(2) The application must:

(a) be received by the Commissioner within 7 days after the day when the person or body is given a copy of the determination; and

(b) state the reasons why review of the determination is sought, other than mere dissatisfaction with the determination.

(3) An application may be supported by additional information.

[8] Section 10.72

substitute

10.72 Constitution of Determination Review Panel

(1) The Determination Review Panel consists of:

(a) if the Commissioner for Complaints has not been involved in the resolution of the complaint:

(i) as chairperson, the Commissioner; and

(ii) a person appointed by the Commissioner from the panel of potential chairpersons; or

(b) if the Commissioner has been involved in the resolution of the complaint — 2 persons appointed by the Commissioner from the panel of potential chairpersons, one of whom the Commissioner must appoint as chairperson.

(2) The panel appointed to deal with a particular complaint must be constituted within 7 days after the application for review is made to the Commissioner.

(3) If a member of the panel ceases to be a member, the Commissioner may reconstitute the panel for the review.

[9] Section 10.73

omit

As soon as practicable

insert

(1) As soon as practicable

[10] Section 10.73

insert

(2) The panel must also ask the committee that heard the complaint to give it the information mentioned in paragraphs 10.74 (2) (a) and (b).

(3) The committee must give the panel the information as soon as practicable after receiving the request.

[11] Subsection 10.77 (1)

substitute

(1) The Minister must appoint a Commissioner for Complaints.

[12] Subsection 10.77 (2)

omit

as the National chairperson

[13] Subparagraph 10.77 (2) (b) (iii)

omit each mention of

National chairperson

insert

Commissioner

[14] Subparagraph 10.79A (a) (i)

substitute

(i) as chairperson, the Commissioner for Complaints; or

[15] Paragraph 10.79A (b)

omit

3

insert

2

[16] Section 10.80

omit

a Complaints Resolution Committee's procedures.

insert

procedures to be followed by a Complaints Resolution Committee and a Determination Review Panel.

[17] Section 10.81

omit

In performing

insert

(1) In performing

[18] Section 10.81

insert

(2) This section applies to a Determination Review Panel in the same way as it applies to a committee.

[19] After section 10.87

insert

10.87A Interpretation of this Part

Unless the contrary intention appears, a reference in this Part to a member includes a reference to the Commissioner for Complaints.

[20] **Section 10.92**

substitute

10.92 Resignation

(1) The Commissioner for Complaints may resign by signed notice of resignation given to the Minister.

(2) A member of the committee, other than the Commissioner, may resign by signed notice of resignation given to the Secretary.

[21] **Subsection 10.93 (1)**

omit

The Secretary may terminate a member's appointment

insert

The appointment of a member may be terminated

[22] **After subsection 10.93 (1)**

insert

(1A) The appointment of a member may be terminated:

(a) if the member is the Commissioner for Complaints — by the Minister; and

(b) otherwise — by the Secretary.

[23] **Section 10.94**

substitute

10.94 Leave of absence

A member of a committee may be granted leave of absence:

(a) if the member is the Commissioner for Complaints — by the Minister; and

(b) if the member is a chairperson (other than the Commissioner) — by the Secretary; and

(c) otherwise — by the chairperson of the committee.

[24] Additional amendments

Provision	*omit*	*insert*
Paragraph 10.34 (d)	Minister	Commissioner for Complaints
Paragraph 10.34 (e)	Minister	Commissioner
Paragraph 10.47 (3) (a)	National chairperson	Commissioner for Complaints
Paragraph 10.47 (3) (b)	National chairperson's	Commissioner's
Section 10.77, heading	**National chairperson**	**Commissioner for Complaints**
Subsection 10.77 (3)	National chairperson	Commissioner
Subparagraph 10.79A (a) (ii) and paragraph 10.79A (b)	Secretary	Commissioner
Subsection 10.101 (3)	National chairperson	Commissioner for Complaints

SUMMARY OF FACILITIES UNDER SANCTIONS ACTION (#24 as at 20 November 2000)

Facility	Facility Address	Approved Provider	Sanctions Applied	Date Sanction Imposed	Reason for Sanction	Current Status of Service
Kenilworth Private Nursing Home	3 Kenilworth Parade IVANHOE VIC 3079	Neviskia Pty Ltd	Sanction 1 No Commonwealth funding for new residents for a period of 9 months. No further allocation of places for a period of 12 months.	Sanction 1 24 March 2000	Sanction 1 Provider did not comply with all its responsibilities in relation to quality of care. The Department found there was immediate and severe risk to the safety, health or well being of residents.	Sanction 1 Sanctions in place. Provider sought reconsideration of the decision to impose sanctions The original decision was confirmed 25 July 2000. The provider applied for a stay of the sanctions (Sanction 1). The hearing of the stay application was held on 29 September 2000. The application was refused.
			Sanction 2 No Commonwealth funding for new residents for a period of 12 months. No further allocation of places for a period of 12 months.	Sanction 2 24 May 2000	Sanction 2 Provider did not comply with its responsibilities in relation to Quality of accountability.	Sanction 2 Provider sought a reconsideration of the decision to impose sanctions. The original decision was confirmed on 11 September 2000.

Last saved by Marchd 20/11/00

TABLED 22-11-00

SUMMARY OF FACILITIES UNDER SANCTIONS ACTION (#24 as at 20 November 2000)

						Provider applied for a stay of the sanctions (Sanction 3). The hearing of the stay application was held on 29 September 2000. The application was refused.
			Sanction 3 Revocation of 5 places.	Sanction 3 20 Sept 2000	Sanction 3 Provider did not comply with all its responsibilities in relation to quality of care.	Sanction 3 Sanctions in place. Provider has sought a reconsideration of the decision to impose sanctions. The original decision was confirmed on 13 October 2000.
			Sanction 4 Revocation of 5 beds	Sanction 4 3 November 2000	Sanction 4 Provider did not comply with all its responsibilities in relation to quality of care. The Department found there was immediate and severe risk	Sanction 4 Sanctions in place.

Last saved by Marchd 20/11/00

					to the safety, health or well being of residents.	

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question No: E037**

Topic: BEYOND BLUE

Written Question on Notice

Senator Evans asked:

(a) What has been the basis of Mr Kennett's employment as Chair of the depression initiative since 30 May when his previous arrangement expired?

(b) How many days work was Mr Kennett paid for up to the announcement the new Board for the initiative on October? Was this at the previous rate of $1,900 a day?

(c) On whose advice was it decided to establish the initiative as a private company?

(d) On whose advice was the name changed to Beyond Blue and did the Department express a view about that name?

(e) What has been the total spending on the depression initiative to date?

(f) What actual programs have commenced operation under this banner to assist people with depression?

Answer:

(a) The original contract with Mr Kennett was for a period of 12 weeks from 14 March 2000 to 30 May 2000. This contract was varied to extend the period to 30 November 2000 or until formal establishment of the company under which the Initiative operates. Formal registration of the company occurred on 19 October 2000. The variation in the contract was to allow Mr Kennett's continued contribution to the development of the Initiative.

(b) Fees under the original and varied contract were payable at $1,900 per day. In the financial year 1999-00 a total of $19,000 for 10 days work was paid under the contract. For the period July to October 2000 a total of $35,971.35 was paid for approximately 19 days work.

(c) The decision to take forward the National Depression Initiative via a public company under Australian Corporations Law was a matter agreed upon by the Commonwealth and Victorian Governments.

(d) The decision to adopt the name Beyond Blue for this public company was that of the Board of Directors of the Company.

(e) Approximate total spending associated with the development work across the eight-month period March-November 2000 was $262,000 to the Commonwealth. This includes costs associated with development and registration of the company and associated legal documents, selection and appointment of the Board and initial Board meetings, negotiations with jurisdictions and development of the MoU, recruitment and appointment of Chief Executive Officer and funding of additional Commonwealth staff, and establishment of premises.

(f) Beyond Blue Limited was registered with the Australian Securities and Investment Commission on 19 October 2000. The Inaugural Chief Executive Officer, Professor Ian Hickie, took up his appointment in early November 2000. Since that time focus of work has been on the practical establishment of the Company including selection and refurbishment of premises, engagement of legal and financial support, establishment of bank accounts and tax status etc. No funding of programs will occur until this initial establishment phase is complete. In addition, no program funding or delivery will occur until the Draft Strategic Plan, currently being developed, has been approved by the Members, of which the Commonwealth is one.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E081**

Topic: BEYOND BLUE

Hansard Page: CA 75

Senator Gibbs asked:

(a) Could we have a breakdown of funds and areas where money has been spent? Consultancies, capital, staffing, program delivery?

(b) Provide copies of the constitution of the company.

Answer:

(a) The work of the National Depression Initiative will be progressed through *Beyond Blue*, an independent public company limited by guarantee and established under the Corporations Law of Australia. The Commonwealth is a senior funding member of *Beyond Blue* and holds a one-third voting interest under the Constitution of the Company. As a company established under Corporations Law of Australia, *Beyond Blue* is required to report all financial activities in accordance with the reporting requirements of the Corporations Act 1989. All such information will be provided to the Commonwealth, though the Department of Health and Aged Care, in its role as Voting Member of the Company. All such reports on financial activities will be made available to the Senate once received by the Department.

(b) A copy of the Constitution is provided at Attachment A.

Note: full text of Constitution not included

Corporations Law

A Company Limited by Guarantee

CONSTITUTION

of

BEYOND BLUE LIMITED

Level 18 333 Collins Street Melbourne VIC 3000 Australia
DX 31314 Mid Town
Tel + 61 3 9286 6000 Fax + 61 3 9629 8488
Our ref – 167/1528815 Contact - Brian Doyle

Melbourne • Sydney • Brisbane • Perth • Canberra • Darwin

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question No: E082**

Topic: RURAL DOCTORS

Hansard Page: CA 77

Senator West asked:

Do you have them broken down into 3, 4, 5, 6 and 7?

Answer:

The latest data available (Table 1) suggest that the number of non-specialist medical providers practising in rural and remote areas increased by about 11.8% over the last three years, with the increase being greatest in remote areas and smallest in large rural centres.

The increase in terms of full-time workload equivalents was 0.9% in rural and remote areas over the last three years (Table 2). The increase was highest in other remote areas.

The increase of full-time equivalents was lower than the increase in the number of non-specialist medical providers practising in rural and remote areas, being 3.9% (Table 3). Again, the greatest increase was in other remote areas.

Table 1: Number of medical practitioners billing Medicare by region[(a)],1996-97 to 1999-2000

Region	Number of medical practitioners				Percentage change
	1996/97	1997/98	1998/99	1999/2000	over 3 years
Large rural centre	1357	1337	1377	1390	2.4
Small rural centre	1295	1310	1375	1474	13.8
Other rural area	2296	2332	2435	2542	10.7
Remote centre	239	248	296	309	29.3
Other remote area	368	457	485	495	34.5
Total rural & remote	**5555**	**5684**	**5968**	**6210**	**11.8**

(a) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Table 2: Full-time workload equivalents[(a)] (FWEs) for medical practitioners billing Medicare by region[(b)],1996-97 to 1999-2000

Region	Number of medical practitioners				Percentage change
	1996/97	1997/98	1998/99	1999/2000	over 3 years
Large rural centre	926	946	941	929	0.3
Small rural centre	925	930	923	939	1.5
Other rural area	1465	1470	1467	1472	0.5
Remote centre	116	121	115	112	-3.4
Other remote area	121	131	133	132	9.1
Total rural & remote	**3553**	**3598**	**3579**	**3584**	**0.9**

(a) "FWE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners over the reference period ($186,742 for 1999/2000). For example, an FWE value of 2 means their billing was twice the average - ie. $373,484). The FWE values are then added together to produce aggregate numbers for each region.
(b) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Table 3: Full-time equivalents[(a)] (FTEs) for medical practitioners billing Medicare by region[(b)],1996-97 to 1999-2000

Region	Number of medical practitioners				Percentage change
	1996/97	1997/98	1998/99	1999/2000	over 3 years
Large rural centre	796	815	814	819	2.9
Small rural centre	812	824	824	851	4.8
Other rural area	1340	1348	1355	1379	2.9
Remote centre	99	105	104	104	5.1
Other remote area	116	124	134	133	14.7
Total rural & remote	3163	3216	3231	3286	3.9

(a) "FTE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners over the reference period ($186,742 for 1999/2000). The total FTE value for a doctor is then capped at 1, regardless of how busy the doctor is (which has the effect of understating overall Medicare activity). FTEs are counted against each region that doctors record activity during the reference period, rather than just the last quarter of available data.
(b) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E038**

Topic: RURAL DOCTOR NUMBERS

Hansard Page: CA 77/written question on notice

Senator West/Evans asked:

(a) Can the Department please provide detailed figures for the number of doctors practicing in each category of rural and remote area on the basis of full time equivalent doctors for 1998/99 and 1999/2000? Are similar numbers available for the breakdown between GP's and specialists?

(b) What data does the Department have on the number of practicing doctors moving in and out of practicing in each rural and remote area for 1998/99 and 1999/2000?

(c) What is the breakdown of these figures between:
1. **Fully qualified doctors with vocational registration**
2. **Practitioners without vocational registration**
3. **Trainees undertaking a registrar placement**
4. **Graduate students undertaking a placement**
5. **Undergraduate students providing assistance**

(d) How many doctors in rural areas are practicing there under:
1. **An exemption scheme related to Overseas trained doctors in Australia as temporary residents.**
2. **Schemes for Overseas trained doctors being given permanent Australian residency.**

Answer:

(a) Table 1 shows the number of full time equivalent medical practitioners (general practitioners and specialists) billing Medicare in each category of rural and remote area for 1998-99 and 1999-2000.

Table 1: Full-time equivalents[(a)] (FTEs) for medical practitioners billing Medicare by specialty and region[(b)], 1998-99 to 1999-2000

Specialty	Region	1998-99	1999-2000
General practitioner	Large rural centre	814	819
	Small rural centre	824	851
	Other rural area	1355	1379
	Remote centre	104	104
	Other remote area	134	133
	Total rural & remote	**3231**	**3286**
Specialist	Large rural centre	726	746
	Small rural centre	348	353
	Other rural area	138	146
	Remote centre	16	16
	Other remote area	4	4
	Total rural & remote	**1,233**	**1,266**

(a) "FTE" values are derived for each practitioner by dividing the schedule fee value of their services by the average for full time practitioners over the reference period ($186,742 for 1999/2000). The total FTE value for a doctor is then capped at 1, regardless of how busy the doctor is (which has the effect of understating overall Medicare activity). FTEs are counted against each region that doctors record activity during the reference period, rather than just the last quarter of available data.
(b) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.

(b) Table 2 shows the number of general practitioners moving in and out of each rural and remote area for 1998-99 and 1999-2000. For example, of the 1375 doctors who were billing in small rural centres in 1998-99, 1147 were still there in 1999-2000, 86 ceased billing, 85 moved to Metropolitan areas, 13 moved to large rural centres, 35 moved to other rural areas, 3 moved to remote centres and 6 moved to other remote areas. Specialists have not been included because the use of major practice Postcode does not adequately reflect the presence of visiting specialist services in rural areas.

Table 2: General practitioners billing Medicare by region[(a)] in 1998-99 and 1999-2000

1998-99	1999-00							
	Not Billing	Metro-politan	Large rural centre	Small rural centre	Other rural area	Remote centre	Other remote area	Aust
Not Billing		1182	131	177	407	65	160	2122
Metropolitan	1502	16433	46	61	110	24	32	18208
Large rural centre	102	72	1132	20	42	3	6	1377
Small rural centre	86	85	13	1147	35	3	6	1375
Other rural area	214	178	45	53	1905	14	26	2435
Remote centre	42	29	6	9	15	183	12	296
Other remote area	118	45	17	7	28	17	253	485
Aust	2064	18024	1390	1474	2542	309	495	

(a) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994.
(b) Doctors are classified to a region on the basis of their major practice Postcode in the June Quarter of each year.

(c) The latest data available (Table 3) show that the 11.8% increase in rural general practitioner numbers over three years is greatest for other non-specialist medical practitioners (33.2%), and more modest for vocationally registered general practitioners and for GP registrars (6.0% and 5.1% respectively). Graduate students undertaking placements cannot be identified separately in the Medicare data. Undergraduates providing assistance in rural areas will not appear in these figures as they do not have access to Medicare.

Table 3: Number of general practitioners billing Medicare in RRMAs[(a)] 3 to 7, by type of practitioner, 1996-97 to 1999-2000

	Number of general practitioners				Percentage change
	1996-97	**1997-98**	**1998-99**	**1999-00**	**Over 3 years**
Vocationally registered general practitioners	3963	4077	4141	4199	6.0
General practice registrars	391	359	409	411	5.1
Other non-specialist medical practitioners (OMPs)	1201	1248	1418	1600	33.2
Total	**5555**	**5684**	**5968**	**6210**	**11.8**

(a) The region categories are as per the Rural, Remote and Metropolitan Areas Classification, 1991 census edition, Commonwealth Department of Primary Industries and Energy, Commonwealth Department of Human Services and Health, November 1994. RRMAs 3 to 7 include all rural and remote centres.

(d) In answer to part 1 of this question, Table 4 shows the estimated number of exemptions granted under section 3J of the *Health Insurance Act 1973* (the Act) to allow temporary resident doctors to provide professional services that attract a benefit under the Medicare Benefit Schedule, in rural areas classified as RRMA 3-7.

Under the new State and Territory overseas trained doctor recruitment schemes there are currently 79 overseas trained doctors practising in Queensland, Western Australia and Victoria. The scheme is currently being implemented in the other States and the Northern Territory. So far sixteen doctors working on these schemes have been awarded permanent residency or citizenship.

Table 4: Exemptions under section 3J granted to allow temporary resident doctors to provide professional services under Medicare , in RRMA 3-7

	Number of exemptions[(a)]	**Number of medical practitioners[(b)]**
1998/99	939	Not available
1999/00	2081	685

(a) The number of exemptions is greater than the number of doctors, reflecting the fact that many of the doctors worked in more than one rural location and some doctors renewed short-term locum exemptions throughout the year.

(b) It should be noted that an additional number of temporary resident doctors work in State and Territory public hospitals and have access to a "class exemption" under section 3J of the Act to refer and prescribe only.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E083**

Topic: UNDERGRADUATE TRAINING DOCTORS

Hansard Page: CA 78

Senator West asked:

Are you able to break down the figures for those people that are out there – that 11 per cent of extra bodies – in terms of fully qualified with vocational registration, practitioners without vocational registration, trainees undertaking registrar placement, graduate students undertaking placement and undergraduates providing assistance?
I am more interested in the fully qualifieds, the practitioners without vocational. The Registrars should be relatively easy as well, I would have thought.

Answer:

The latest data available (Table 1) show that the 11.8 per cent increase in rural doctor numbers over three years is greatest for other non-specialist medical practitioners (33.2%), and more modest for vocationally registered general practitioners and for GP registrars (6.0% and 5.1% respectively). Graduate students undertaking placements cannot be identified separately in the Medicare data. Undergraduates providing assistance in rural areas will not appear in these figures as they do not have access to Medicare.

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Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E124**

Topic: RURAL DOCTOR TRAINING

Written Question on Notice

Senator Crowley asked:

(a) What was the basis on which funds were recently allocated to the Australian College of Rural and Remote Medicine for rural doctor training?

(b) Can a copy of the submission for these funds and any other documents setting out the purpose and performance indicators for this grant be provided?

(c) Why were no other bodies given a chance to bid for these funds given the overall shift towards "contestability?"

Answer:

(a) Funding will be allocated to the Australian College of Rural and Remote Medicine (ACRRM) to develop a comprehensive program that will provide innovative models of rural medical training and efficient methods of professional development for doctors in rural areas. The program will facilitate the development and retention of a range of vital primary and advanced rural skills.

The proposal is consistent with the Government's reform agenda for vocational training and will assist with the development of responsive and innovative regional models for vocational training and professional skills development. In this regard, ACRRM have proposed a collaborative approach with rural consortia to develop and trial innovative approaches to rural training and to build an integrated program for rural professional skills development.

(b) The funding agreement between the Commonwealth and ACRRM is currently being developed, and has not yet been signed by either party. When finalised, a copy will be provided to the Committee.

(c) ACRRM and the Royal Australian College of General Practitioners are the two most significant players in general practice education and training at the national level. However, ACRRM is poorly resourced for the role it will be expected to play from 2001 onwards. The funding that will be allocated to ACRRM is in recognition of the need to develop the organisation's capacity as a significant national body. It is not intended to give it an advantage within the contestable

training regime that will apply from the beginning of 2002. Indeed, a primary purpose of the ACRRM funding is to support and facilitate the establishment of rural and regional training consortia, which will involve the participation and co-operation of a range of players at the regional level.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E125**

Topic: RURAL DOCTOR TRAINING

Written Question on Notice

Senator Crowley asked:

How much does the Department currently spend: and what is the breakdown of expenditures for each category; for:

(a) Retention of rural doctors
(b) Rural workforce agencies
(c) Overseas doctor programs
(d) Trainee doctor programs

Answer:

(a) $10,849,522 in 1999/2000 (accrual)

(b) Rural & Remote General Practice Program Contract payment $14,400,000

1. First instalment under the variation to the Contract (for capacity building & additional priorities $ 986,800
2. First instalment to NSW Rural Doctors Network (to establish Australian Rural & Remote Workforce Agencies Group Limited) $ 43,316.25

1999/2000 (accrual) TOTAL $15,430,116

(c) During 1999 the Department agreed to provide $500,000 support for Western Australia and $300,000 to Queensland to establish State initiatives that focus on placement of overseas trained doctors in remote areas where there is a workforce shortage. There are currently negotiations between the Department and Tasmania and the Northern Territory to provide funding to assist these states.

A total of $1.45 million was paid to universities involved with the '100 places program' in the 1999/00 year:

- there are currently 73 doctors, in eight medical schools, participating in the program;
- on successfully completing their courses, these overseas trained doctors will become part of the rural medical workforce through their internship, clinical assistantship (if required), post-graduate training, and then for a further five years as a qualified medical practitioner.

This initiative started at the beginning of the 1999 academic year for overseas trained doctors to gain Australian medical qualifications, in return for five years work in a rural area.

For the 1999/2000 financial year $75,000 was paid to the Networked Dermatology Project and $32,500 was paid to the Radiology Project for the community based training of overseas trained doctors.

A further $78,994 was paid in relation to the review of bridging courses for overseas trained doctors, which reported to, and was wound up by, the Australian Health Minister's Advisory Committee at its meeting in October 1999.

The total of the above amounts which have been recently spent on overseas doctor programs is $2,357,500, excluding the amount for the bridging course review which has ceased.

(d)

Registrar Programs	$51,783,998
Undergraduate Programs (including scholarships)	$ 5,775,496
TOTAL	$57,559,494

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E126**

Topic: RURAL DOCTOR TRAINING

Written Question on Notice

Senator Crowley asked:

(a) How will the Board of General Practice Education and Training balance its narrow fund holding role for issuing contracts with the broad strategic policy role suggested by the Ministerial Review?

(b) Why was NACCHO not included in the list of organisations asked to nominate Board members, when it was included in the groups originally designated as being involved in the Board?

(c) What steps is the Government taking to ensure that the new Board will adequately represent the interests of Australians living in smaller States and Territories?

(d) I note that professional associations are not requested to even consider the gender of their nominees. In this context, I note that "General Practice in Australia: 2000" shows that female non-specialist medical practitioners billing Medicare has increased by 109% over the past 14 years to 33% of the profession. What steps is the Government taking to ensure that the new Board will adequately represent the interests of female general practitioners?

(e) Why was the General Practice Supervisors Association not included on the Board?

Answer:

(a) The primary function of General Practice Education and Training Limited will be to set and manage strategic directions for general practice education and training. It will manage the funds associated with the provision of vocational training as required by the company constitution. The Board of Directors will have particular expertise in general practice education and training to ensure that such a balance is achieved.

(b) The Minister is currently considering who will be appointed as Directors on the Board of General Practice Education and Training Limited. These individuals will have specific legal obligations associated with management of a company. The Board has the capacity to be supported by an Advisory Council in setting strategic directions, and this will include a range of players in general practice education and training. It would be appropriate for an indigenous representative to be included on the Advisory Council. However, this will be a matter for the Board.

(c) The primary function of General Practice Education and Training Limited is to provide national vocational training that is appropriate to regional needs. Representatives on the Board and the Advisory Council will include representatives from national organisations, and the company constitution will ensure that all key stakeholder interests are considered.

(d) The Minister is currently considering membership of the Board, and the issue of gender balance is being addressed. All appointments to the Board must be approved by Cabinet which requires a balance with regard to gender and geographical location.

(e) Please refer to (b) Representation on the Advisory Council will be considered by the Board.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E127**

Topic: BOARD RESOURCES

Written Question on Notice

Senator Crowley asked:

What operational support does the Government intend to provide to the Board?

(a) How many staff will the Board be provided and at what levels?

(b) Will the operational arm be able to account direct to the Board or will support come through the Department of Health and Aged Care?

(c) What measures are being taken to ensure the policy and management of GP training does not simply become a function of the Department?

(d) What measures are being taken to ensure the policy and management of GP training does not simply become a function of the Department?

Answer:

(a) The Department will have an annual funding agreement with General Practice Education and Training Limited to provide funds for administration of the company.

(b) This will be a decision for the Board.

(c) The Board will be responsible for operational funds. Please refer to (a).

(d) General Practice Education and Training Limited will be a Commonwealth controlled company established under the *Commonwealth Authorities and Companies (CAC) Act 1997* and Corporations Law.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E128**

Topic: RURAL TRAINING BOARD – CONFLICT OF INTEREST

Written Question on Notice

Senator Crowley asked:

> **The Minister's letter of 13 October says that the Board "will enable the profession, the Government and communities to work in partnership….."yet the attachment stresses that the Board will be a Commonwealth Company that "the Director's first duty must be to the company." If all the members are legally bound to act as individuals, how can they, at the same time, foster a partnership amongst their member organisations?**

Answer:

> As Directors of the Board of General Practice Education and Training Limited, individual members will be bound by the company constitution to work collaboratively in facilitating partnerships between the profession, Government and communities.
>
> Whilst their first obligation is to the company, the Directors will be specifically chosen to represent the views and perspectives of the key players in general practice education and training, and they will bring their specific perspectives and expertise to the Board.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E129**

Topic: ADVISORY COUNCIL

Written Question on Notice

Senator Crowley asked:

(a) What is the Advisory Council's role and membership? From where will it receive its funds? How much will it receive?
(b) Will these funds, or any funds for regionalisation, come from the Memorandum of Understanding?
(c) Will the membership of the Advisory Council reflect the suggestion made in the RACGP document "Let's get it right", for a wider "reference group" including the AMA, the National Rural Health Alliance, rural workforce agencies and other stakeholders?
(d) Will there be state and regional fora inputting to the Board to ensure that the views of smaller States and Territories are taken into account?

Answer:

(a) The Advisory Council will be required under the constitution to provide advice and make recommendations to the Board on matters relating specifically to general practice vocational training. Membership of the Advisory Council will be for the Board to consider. Funding for the Advisory Council will be provided by the company, under direction of the Board of Directors.

(b) Funding for a range of general practice issues, including vocational training, regionalisation, and the establishment of the Board, is covered by Clause 21 of the GP MoU, which provides for the maintenance of general practice infrastructure, training and support programs.

(c) Membership of the Advisory Council will be considered by the Board.

(d) The company's consultative framework is a matter to be considered by the Board.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E130**

Topic: SUPPORT FOR REGIONALISATION

Written Question on Notice

Senator Crowley asked:

(a) What are the regions that the Government has decided to structure the training groups around? How were these regions boundaries determined?
(b) Will the regions correlate with State, regional health authority, Division of General Practice boundaries?
(c) How has the Government determined that the contestability process will ensure that regional areas have sufficient general practitioners to meet their needs?

Answer:

Regionalisation and contestability will be priority matters for the Board to determine, in consultation with the key stakeholders.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E131**

Topic: COMPETITION AND COLLABORATION

Written Question on Notice

Senator Crowley asked:

(a) How will the proposed competitive environment affect collaboration and support between organisations in a region?

(b) Won't the use of 'comparative competition' between regions deter them from cooperating? Will it lead to divergence between teaching standards in different regions?

(c) Will contestability apply within regions? – Will the Government be seeking competing bids for the same set of educational services?

(d) Will contestability apply between regions? – Will the focus be on different regions promoting better more efficient services to snare limited resources? If so, how will the Government ensure that less prepared, more remote regions are not disadvantaged?

(e) Has the Government considered using a funding allocation based on population, socio-economic and health criteria?

(f) What evidence is there that the use of competition has a greater impact on system inefficiencies than collaborative strategies and incentives?

Answer:

(a) The Government is keen to foster collaboration between regional organisations, of which there is already growing interest in many States.

(b) As mentioned above, contestability can include collaborative models that facilitate cooperation between organisations, and the Board will work closely with the profession to ensure standards are maintained.

(c) Contestability will be a matter for the Board to determine.

(d) Contestability will be a matter for the Board to determine.

(e) Funding allocations will be a matter for the Board to determine.

(f) In Australia, contestability has been introduced into a range of markets/programs. The benefits of introducing a contestable environment include: clarification of program goals and objectives; encouragement of continuous improvement and innovation; increasing performance and impact on outcomes; greater responsiveness to client needs; improvements in the quality of goods and services; flexibility is offered to those operating in traditional bureaucratic modes by opening up the prospect of alternative and better ways of doing business; and encouragement of providers in traditionally cloistered markets to search beyond the conventional manner of production and adopt a more "customer focus".

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E132**

Topic: CONTESTABILITY – THE TENDER PROCESS

Written Question on Notice

Senator Crowley asked:

Does the government intend that only graduates from the new Training Program would be able to attract vocational registration?

Answer:

No. The attainment of vocational recognition is open to a range of medical practitioners, including doctors who have completed the General Practice Vocational Training Program (GP registrars), Other Medical Practitioners (OMPs), and overseas trained doctors. The development of alternative pathways during 2001 will assist in helping doctors, particularly in rural areas, to obtain vocational recognition.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E133**

Topic: CONTESTABILITY – THE TENDER PROCESS

Written Question on Notice

Senator Crowley asked:

> **In a context where the contestability process itself makes clear that a range of providers could deliver general practice education, how can the Government maintain this restriction and still honour the national competition principles?**

Answer:

> There is no restriction on who can attain vocational recognition. A contestable framework complies with national competition principles.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E134**

Topic: CONTESTABILITY – THE TENDER PROCESS

Written Question on Notice

Senator Crowley asked:

> **Will competing consortia be allowed to tender on delivering models other than the current model?**

Answer:

This will be a matter for the Board to determine. However, it is expected that the new arrangements will provide greater flexibility and innovation in general practice training, within the current standards.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E135**

Topic: CONTESTABILITY – THE TENDER PROCESS

Written Question on Notice

Senator Crowley asked:

How will national priorities such as Aboriginal health or remote placements be protected?

Answer:

The new arrangements are designed to better meet the needs of local communities. In this regard, the arrangements will facilitate registrar experience in a range of communities, including indigenous communities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E136**

Topic: CONTESTABILITY – THE TENDER PROCESS

Written Question on Notice

Senator Rosemary Crowley asked:

As regional consortia will be under competitive pressure to deliver a higher rural retention rate, how will the Government guarantee that female graduates will not be discriminated against when statistics show that female graduates are more likely to be part-time and to have interrupted careers?

Answer:

The new arrangements are designed to have greater flexibility and to meet the needs of all general practice registrars. Specific criteria for tendering and assessment will be set by the Board of General Practice Education and Training Limited.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E137**

Topic: IMPACT OF REGIONALISATION

Written Question on Notice

Senator Crowley asked:

> **Will a fragmented, low-cost oriented and competitive system further advantage corporate medicine which has less interest in long term outcomes and a focus on short term profitability?**

Answer:

> The new arrangements are designed to be collaborative, provide value for money, and ensure the continued maintenance of high standards of general practice vocational training.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E138**

Topic: IMPACT OF REGIONALISATION

Written Question on Notice

Senator Crowley asked:

> **How will registrars be able to move between States and regions if these are independent consortia?**

Answer:

> The new arrangements will ensure that transfer arrangements will be appropriately responsive and flexible to suit the training needs of registrars. Specific mechanisms will be considered by the Board.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E139**

Topic: IMPACT OF REGIONALISATION

Written Question on Notice

Senator Crowley asked:

> **I presume that, if this process is not a cost-cutting exercise, and the Board is genuinely independent, some regions may cost less, some regions may cost more, for example, if they want to pursue local initiatives? If so, will the Board have the freedom to allocate different funding levels to different regions? In aggregate, does the Government expect that the budget for General Practice Education will cost more or less for the same number of places?**

Answer:

> The Board will determine where the funds will need to go to ensure high quality training is delivered throughout Australia. It is expected that funding will be commensurate with the number and type of training places available in each region. The funding budget for General Practice Education and Training is limited by the Budget allocation.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E140**

Topic: TRANSITION ARRANGEMENTS

Written Question on Notice

Senator Crowley asked:

(a) What is the transition period? The Ministerial Review said "the timeframe for establishing this new system would be two to three years." The Board is yet to meet yet the Government expects the Board to be in a position to have its first registrars in the field within 15 months.

(b) Doesn't the current timeframe pre-empt the freedom of the new Board to determine standards and process?

Answer:

(a) The profession has been preparing for the transition since the announcement of the new arrangements in June 2000. The Board will manage further transitional arrangements from 2001 to ensure that a regional, contestable framework is operational by 2002.

(b) Responsibility for standards will remain primarily with the medical profession.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E141**

Topic: SYSTEM QUALITY MANAGEMENT AND EDUCATION

Written Question on Notice

Senator Crowley asked:

What will the Government do to maintain the quality improvement and outcome evaluation currently deployed within the sector?

Answer:

This will be an issue to be considered by the Board.

Senate Community Affairs Legislation Committee
ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E142**

Topic: SYSTEM QUALITY MANAGEMENT AND EDUCATION

Written Question on Notice

Senator Crowley asked:

Will the Government commit to ongoing use of RACGP quality standards and leave the profession the independence to vary them according to professional needs?

Answer:

The level and nature of General Practice professional standards is a matter of significant community interest. The standards need to be set by the profession. Governments have to work with the profession to ensure that standards meet community needs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E143**

Topic: SYSTEM QUALITY MANAGEMENT AND EDUCATION

Written Question on Notice

Senator Rosemary Crowley asked:

> **Will the Government continue to support the professional standards set by the clinical colleges recognised by the Australian Medical Council?**

Answer:

> Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E144**

Topic: SYSTEM QUALITY MANAGEMENT AND EDUCATION

Written Question on Notice

Senator Rosemary Crowley asked:

> **In particular, will any competitive tendering criteria require bidders to prepare the GP registrars to sit the Fellowship examination of the RACGP and for their training practices, GP teachers, curriculum delivery and assessment processes to meet defined RACGP standards?**

Answer:

> The Fellowship of the RACGP is the only end-point for general practice vocational training. Thus, although regional training providers will have scope to tailor vocational training to suit regional needs, they will need to work within the current RACGP standards regime. In practice, this will mean that regional training providers must prepare registrars to sit the RACGP examination. They will therefore be required to ensure that their training curricula covers the core competencies set by the RACGP, and that their GP educators and training practices are suitably accredited to current RACGP standards.
>
> Specific tendering criteria will, however, be set by the Board of General Practice Education and Training.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 4: QUALITY HEALTH CARE **Question: E145**

Topic: SYSTEM QUALITY MANAGEMENT AND EDUCATION

Written Question on Notice

Senator Rosemary Crowley asked:

> **The Government has advised the RACGP that "the medical profession will remain the final arbiter on matters of general practice training curricula." Does this statement mean that the Board will consist exclusively of members of the medical profession or that only Board who are members of the medical profession would participate in any such decisions?**

Answer:

> Membership of the Board will reflect the key organisations and sectors of the medical profession, particularly general practice. It is envisaged that the profession will work closely with the Board on issues regarding quality of training and standards.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 5: RURAL HEALTH **Question: E085**

Topic: RURAL HEALTH SERVICES

Written question on notice

Senator Evans asked:

(a) How many Regional Health Services were approved on 30 June 2000 and how many were actually operating?

(b) How many are operating now?

(c) Can you provide an update of the table tabled in May on page 127 of Volume 3 of the Additional Information from the May hearings?

Answer:

(a) At 30 June 2000, there were 138 services approved under the Regional Health Services Program, of which 114 were operational.

(b) There are currently 135 services operational.

(c) An updated table is attached.

Attachment Question: 085

Regional Health Services Program Overview – 31 November 2000

(Update of document tabled at May 2000 Senate Estimates)

- A total overview of the Program, and the varying elements is as follows:

Approvals under the Regional Health Services Program

	90	91	92	93	94	95	96	97	98	99	00	Total to date
MPC	9	9	10	5		1	1					35
MPS				7	6	7	5	3[1]	13[2]	5	16[3]	62[4]
RHS										2	60[5]	62[5]
Total	9	9	10	12	6	8	6	3	13	7	76	**159**

1 One of these services is approved but not yet operational
2 Three of these services are approved but not yet operational
3 Six of these services are approved but not yet operational
4 Ten MPS are approved but not yet operational
5 Twenty Four RHS are approved but not yet operational

- A State/Territory comparison of approvals is as follows:

	NSW	QLD	VIC	SA	WA	NT	TAS	**Total**
MPC	1	10	12	-	7	1	4	35
MPS	15	9	7	4	23	1	3	62
RHS	1	20	13	10	12	1	5	62
Total	17	39	32	14	42	3	12	**159**

Services/projects expected to be in place under the Regional Health Services Program 1999-2000 to 2002-2003

	Approved as at 20 Nov 2000	Additional Approvals 2000-2001	2001-2002	2002-2003	2003-2004	TOTAL
MPC	35					35
MPS	62	17	6	6	6	97
RHS	62	30	40	30	20	182
TOTAL	159	47	46	36	26	314

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 5: RURAL HEALTH **Question: E068**

Topic: CLINICAL SCHOOLS AND UNIVERSITY DEPARTMENTS

Hansard Page: CA 81

Senator West asked:

A copy of the criteria for deciding where clinical schools and university departments of rural health are to be located is to be provided.

Answer:

Attached is a copy of the letter sent to the Deans of Australian medical schools inviting expressions of interest for the establishment of clinical schools and University Departments of Rural Health. The document sent with this letter outlines the objectives and criteria.

Attachment: Question E068

COMMONWEALTH OF AUSTRALIA

Commonwealth Department of Health and Aged Care

Fishburn House, 2nd Floor
Furzer Street, Woden, ACT 2606
Telephone: (02) 6289 5599 Fax: (02) 6289 1352

Professor
Dean

Dear Professor

I am writing to follow up on our discussions on 7 July 2000 regarding the Government's commitment to establish nine new clinical schools and three additional University Departments of Rural Health (UDRH) across Australia.

The Government's overarching objective for the implementation of these initiatives is to develop a rural focused national network of health professional education and training which is based upon a strategic and collaborative framework.

As raised at our meeting, the mechanism by which these new initiatives will be established is not prescriptive. The broad spectrum of education and training for health professionals has the potential to support a variety of models which facilitate the delivery of education and training in rural areas. Predominantly these have been identified as clinical schools and UDRH, as well as alternative rural health school models seeking to combine the key features of both a clinical school and a UDRH. It is acknowledged that a range of variables will impact on the development and focus of these initiatives, including geographic location, population base, existing infrastructure, and current educational arrangements.

To this end, I would therefore like to invite your medical school to submit an expression of interest regarding the establishment and operation of a clinical school, a UDRH, or alternative rural education and training model, which clearly addresses the attached criteria and objectives. The Department is happy to liaise and provide assistance as necessary to facilitate the development of proposals. If you have any questions, in the first instance please contact Cathy Wall regarding clinical schools (02 6289 5636) or Craig Lindsay regarding UDRH (02 6289 3717).

Expressions of interest are expected to be short, concise submissions, which include an indicative budget. The key features of proposals should be outlined, indicating as to how they will contribute to the Government's Policy Objectives (as follows).

Attachment: Question E068

It is also important that your expression of interest demonstrates support from the relevant State or Territory health department, because of the impact that new educational facilities have on local area health services.

It should be noted that more detailed proposals may be sought during contract negotiation.

I look forward to working with you to establish and implement these new and innovative long-term initiatives for the provision of medical education and training across Australia.

Yours sincerely

Mr Robert Wells
First Assistant Secretary
Health Industry and Investment Division
July 2000

Attachment: Question E068

ESTABLISHMENT OF NEW CLINICAL SCHOOLS, UNIVERSITY DEPARTMENTS OF RURAL HEALTH AND RURAL HEALTH SCHOOLS IN AUSTRALIA

The Federal Budget 2000-2001 provides $562 million for the implementation of a Regional Health Strategy to increase the availability and viability of health services in rural and regional Australia.

One component of the Strategy is the establishment of nine new regional clinical schools and three additional University Departments of Rural Health (UDRH), at a cost of $117.6 million over 4 years. These initiatives will strengthen the rural focus in training for health professionals and increase the number of health professionals in rural and regional areas where the clinical schools and UDRH are located.

Detailed below are the key policy objectives and core criteria seen as imperative to developing and establishing a strong and sustainable national rural education and training network.

Policy Objectives

The Government aims to develop a rural focused national network of medical education and training which:

- Encourages rural students to study medicine and other health professions.
- Enables medical schools to strengthen their presence in rural areas and maximises health professional student training in rural settings.
- Provides strategically located educational facilities in every State and Territory.
- Is based on collaborative models of education.
- Both supports and is supported by rural communities.
- Fosters community development.

Education Models

It is recognised that there is a need for a diversity of models that reflect and accommodate existing educational arrangements and demographic factors such as population distribution.

It is anticipated that the establishment of a strong national education and training network for health professionals will be based upon the following 3 educational models:

Clinical Schools

It is expected that proposals for the establishment of clinical schools should address the following criteria:

- Enable 25% of medical students to undertake a significant part of clinical training in rural Australia.
- Build on existing local and regional infrastructure, including University Departments of Rural Health, regional universities etc.
- Have the capacity to attract and support both specialist and GP teaching staff with clinical loads.
- Demonstrate support from the local medical profession and the local rural community.
- Develop and maintain links with local and regional community at all levels, outlining mechanisms for involving community involvement in all stages of development.

University Departments of Rural Health

Proposals to establish University Departments of Rural Health (UDRH) should demonstrate:

- Ability to establish strategic links and partnerships necessary to establish a multi-disciplinary centre located in a rural or remote setting, which provides academic training and professional development for health care workers.
- Capacity to forge links with academic institutions and other rural/remote health education and training bodies, including clinical schools.
- Capacity to equip a range of health professionals with practical skills in preventive medicine applicable to remote settings.
- Strategies to engender an environment in which health professionals become more culturally aware and sensitive to Indigenous health issues.
- Expertise in preventive and population medicine which will act as a resource for all health professionals working in the area.
- Capacity to develop innovative service delivery models to meet the needs of the identified area.

Rural Health School Models

This model comprises key features of both a clinical school and a UDRH and is likely to be distributed upon a geographical basis. There may be considerable variation in models which are proposed as Rural Health Schools, ranging from a UDRH with some features of clinical school to a clinical school with some features of a UDRH.

Medical schools may wish to expand and develop the role of existing UDRH to encompass clinical school functions to become a Rural Health School. It is acknowledged that some areas of Australia may not have a sufficient population base in discreet areas to support a clinical school as described above. In these areas, it may be most practical to establish a Rural Health School.

Expressions of interest for Rural Health Schools should address criteria from both the clinical school and the UDRH criteria with a clear description of how the functions will complement each other.

Submissions

All expressions of interest, irrespective of their focus, should include:

- A clearly defined set of objectives, outcomes and performance indicators
- A draft workplan.
- Budget estimates.
- Documentation of support from the relevant State or Territory health department.
- Where appropriate, demonstrate collaboration between medical schools, as well as with rural communities, including formal consultation and management mechanisms.
- A draft evaluation strategy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E040**

Topic: REVIEW OF FBT CAP ON ABORIGINAL HEALTH SERVICES

Written Question on Notice

Senator Evans asked:

In a letter (13 April 2000) to the Leader of the Democrats, Meg Lees, from the Treasurer, Peter Costello, regarding the deal they struck on the FBT legislation, the Treasurer stated:
"Regarding the indigenous organisations, particularly health services, the Government will examine the matters you raised prior to the 1 April 2000. I will ask the Minister for Health, in consultation with ATSIC, to coordinate the examination."

(a) What action has been taken to fulfil this commitment?
(b) What processes have been established to examine the impact of the FBT cap on these services?
(c) Have Aboriginal Medical Services been contacted/consulted as part of this investigation?
(d) When will the investigation be completed and when will the outcomes be announced?
(e) Will these services be compensated for the impact of the FBT cap on their capacity to attract and retain staff and if so when will they be informed?

Answer:

The Minister for Health and Aged Care, the Hon Michael Wooldridge MP, wrote to the Leader of the Australian Democrats, Senator Meg Lees, on 10 October 2000 regarding the conduct of an examination into the impact of the FBT cap on Aboriginal and Torres Strait Islander organisations, and provided her with a copy of the examination's terms of reference. The terms of reference were framed to address the issues that the Democrats had raised with the Government.

The Department of Health and Aged Care, in consultation with Aboriginal and Torres Strait Islander Commission (ATSIC), have since engaged consultants to conduct a study involving the voluntary collection of information from Aboriginal and Torres Strait Islander organisations funded by the Commonwealth, including Aboriginal Medical Services. The collection of additional data was considered necessary, as previous studies had not quantified the cost impacts of the revised FBT arrangements across all health, housing, education, legal or employment sectors. The additional data will enable the impacts to be properly assessed and allow alternative options to be fully considered by the government, consistent with its undertaking to the Australian Democrats.

The Department has had discussions with the National Community Controlled Health Organisation (NACCHO) and a number of Aboriginal Medical Services concerning the changes to the FBT legislation and wrote to all organisations about the review in November.

The examination will explore the range of alternative options open to the Government and is expected to be completed by 31 January 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E041**

Topic: ABORIGINAL EYE HEALTH AND AZITHROMYCIN

Written question on notice

Senator Evans asked:

(a) Is the Department aware that due to the high cost of the drug azithromycin some Aboriginal people with Eye disease living in the central desert and communities north and east of Kalgoorlie who have no other health service available to them except that provided by the Western Australian Government's public health service operating out of Kalgoorlie are not receiving the most appropriate treatment available.

(b) In an answer to a Question without Notice on Aboriginal Eye Health last April, Dr Wooldridge said that the drug 'azithromycin' had been put on the 'PBS which had lead to a great increase in the ability to treat eye disease among Aboriginal people.'

As these Aboriginal people have extreme difficulty accessing their entitlements under the PBS will the Department make funding available for the public health services these people access so that they receive azithromycin?

Answer:

(a) The Department is not aware of the policy of the Western Australian Government in relation to the distribution of azithromycin through its public health service operating out of Kalgoorlie.

However, Aboriginal communities located in the central desert and to the north and east of Kalgoorlie are serviced by three Commonwealth-funded Aboriginal community controlled health services (ACCHSs). These ACCHSs are Bega Garnbirringu Health Service, covering the Kalgoorlie and surrounding regions, Ngaanyatjarra Health Service, based in Alice Springs, but servicing central east Western Australia, and Tjuntjuntjara Primary Health Clinic covering a small south eastern region of Western Australia.

Under Section 100 arrangements (discussed below), each of these services can dispense azithromycin to patients free of charge.

(b) On 11 August 1998, the Minister approved special arrangements under Section 100 of the *National Health Act 1953* for the provision of pharmaceuticals through Aboriginal community controlled health services (ACCHSs) in remote areas. These arrangements enable PBS medicines, including azithromycin for the treatment of trachoma, to be supplied free of charge to patients of these services at the point of consultation. Pharmaceuticals are supplied without charge to the patient, and without the need to produce a Centrelink concession card or Medicare safety net card.

In addition, negotiations with the Western Australian Government to extend these arrangements to State-funded remote area Aboriginal Health Services have been underway since July 2000. It is expected that these negotiations will be completed in early 2001. These arrangements are already in place in Aboriginal Health Services funded by the Northern Territory Government.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E0042**

Topic: REVIEW OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER TRAINING

Written Question on Notice

Senator Evans asked:

Australian Health Ministers Advisory Council (AHMAC) members agreed in 1998 to a comprehensive review of Aboriginal and Torres Strait Islander Health Worker training in community and government sectors. National consultation for the review began in 1999. AHMAC members also agreed that priority would be given to developing a national framework for progressing Aboriginal Health Worker (including mutual recognition arrangements) to ensure mobility and career progression.

(a) When will the review be completed and when will it be made available to the public?

(b) The OATSIH website indicates that 'a national action plan should be available late in 2000', when is this action plan expected to be released?

(c) Will the Action Plan be available before the review is completed and released to the public?

Answer:

(a) The National Review of Aboriginal and Torres Strait Islander Health Worker Training, carried out by Curtin University Indigenous Research Centre, is now in draft form and is yet to be considered by the National Reference Group. This is expected to occur early in 2001. The decision to make the final document public will be determined by the Minister.

(b) It is envisaged that OATSIH will be developing a National Indigenous Workforce Strategic Plan which will incorporate findings of several reviews, including the Aboriginal Health Worker Training Review and will be released mid 2001.

(c) No, as information from the National Review of Health Worker training will feed into the National Indigenous Workforce Strategic Plan, it is anticipated that it will be available after completion of the Review document.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E043**

Topic: INCREASE IN FUNDING FOR ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH IN 2000-01

Written Question on Notice

Senator Evans asked:

The response to question 292 asked on 22 May regarding the increase in funding for ATSI health in 2000-01 indicates that "the first of the new services will be established in Central Australia and South Australia".

(a) How many new services will be established and where?

(b) When will these new services receive funding and become operational?

Answer:

(a) The first services under the Primary Health Care Access Program will be established across four local areas (or zones) in Central Australia and five local areas (regions or sub-regions) in South Australia. The local areas were approved for funding by the Minister for Health and Aged Care, the Hon Michael Wooldridge MP, on the advice of the NT Aboriginal Health Forum and the SA Aboriginal Health Partnership. These are bodies involving the four partners - ATSIC, the community controlled health sector, the State or Territory Government and the Commonwealth Government.

The local areas selected are:

Central Australia	**South Australia**
North Barkly	North Metropolitan (Adelaide sub-region)
Anmatjerre	Wakefield
Warlpirri	Hills Mallee Southern
Eastern Arrente-Alyawarre	Riverlands
	Port Augusta sub-region (inc Whyalla, Davenport, Nepabunna and Copley)

The exact number and nature of the new primary health care services in these local areas will depend on the outcome of local planning processes. These planning processes are being managed through the partnership arrangements between ATSIC, the State/Territory Health Department, the NACCHO affiliate and OATSIH and will involve consultation with the Aboriginal and Torres Strait Islander communities in each of these local areas. Funding for planning in these areas will be provided from the program once the planning arrangements are in place. Funds have been provided for planning in Wakefield and the arrangements are expected to be finalised shortly in the other local areas.

(b) Funding to build some staff accommodation in each of the four regions in Central Australia has been provided. Further capital and service needs are being identified through the planning processes which are underway. Services could start to receive funding and become operational during 2001, but this will depend on the outcome of these planning processes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH **Question: E151**

Topic: RESPONSE TO BRINGING THEM HOME

Written Question On Notice

Senator Crossin asked:

Can you provide a breakdown of monies that has been spent, by Department, to date on the following programs:

a) Emotional and Social Wellbeing Regional Training Centres
b) Specialist Indigenous Counsellors
c) Parenting and Family Well-being

Answer:

The figures below are total expenditure under the Bringing Them Home program for the two financial years 1998/99 and 1999/2000. These are the most recent available figures.

a) Emotional and Social Wellbeing Regional Centres Expansion: $2,222,495
b) Counsellors: $8,083,111
c) Parenting and Family Support: $580,301.

Over this same two financial years additional funds of $5,328,868 were also provided to support the Regional Centres under the Social and Emotional Wellbeing Action Plan.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E039**

Topic: PRIVATE HEALTH INSURANCE REBATE

Written Question on Notice

Senator Evans asked:

(a) The Mid Year forecast reports that the cost of the rebate has increased by $390 million in 2000/1 above previous estimates and by $250 million for the year 2003/4. Can you present these figures in the same format as provided in Question 262 from 1 Dec 99 hearings so we can see exactly what the forecast comprises including the breakdown between increased expenditure and increases in the expense of the tax rebate?

(b) Why is the increased cost coming down over time? What assumptions have you made about the participation rate and premium increases over the next three years to arrive at the figure of $250 million increase for 2003/4?

(c) What is your long-term projection for the proportion of people with private health insurance?

(d) In February we were told that the rebate would cost a total of $1,196 million this year for a membership of 6.33 million people which was based on a participation rate of 33%. Now the participation rate has increased to 45.8% which equates to 8.75 million people yet the increase in the cost of the rebate is much less. Can you explain why? In fact if you do the sums the average benefit paid on the February figures is $303 which has now dropped by nearly 15% to an average benefit of $263 for each of the 8.7 million people.

(e) Given that premiums have actually gone up a few percent in the meantime does this mean that people are buying cheaper products which don't give full cover?

Answer:

(a) New accrual estimates for the total cost of the 30% Rebate ($ million) for Additional Estimates are listed in the table below.

Year	Outlays	Revenue	Total
2000-01	1,996	218	2,214
2001-02	2,049	309	2,358
2002-03	2,118	317	2,435
2003-04	2,199	328	2,527

The variations from 2000-01 Budget for the cost of the 30% Rebate ($ million) are listed in the table below.

Year	Outlays	Revenue	Total
2000-01	388	-56	332
2001-02	334	3	337
2002-03	290	-10	280
2003-04	251	-20	231

NB: The cost of the 30% Rebate is split between outlays, administered by the Department of Health and Aged Care and revenue, administered by the Australian Tax Office. Outlays consist of claims made via premium reductions and direct payments. Revenue are claims made through the tax system.

(b) This was the result of an update to the parameters used in the estimation of the cost of the Rebate including the growth factor shown in the table below.

Year	Estimated growth due to increases in insured population, premiums and upgrades	
	2000-01 Additional Estimates	2000-01 Budget
2000-01	41%	12%
2001-02	3%	7%
2002-03	3%	7%
2003-04	4%	7%

(c) The 2000-01 Additional Estimates assume an average participation rate of 45% of the population in 2000-01. This rate is then assumed to remain stable in the outyears.

(d) The main reason the increase in participation is, in percentage terms, greater than the increase in the estimates is due to changes in the calibration between outlays and revenue. Estimates are based on known outlays, as claims for the year through the tax system are not available until the following year. In Additional Estimates this calibration was adjusted to reflect the expectation that a smaller number of claims will be made via tax system. This had a downward effect on the Rebate estimates.

(e) No

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E060**

Topic: 30% REBATE

Hansard Page: CA63 & 64

Senator Evans asked:

(In relation to the tapering off of the estimates for the cost of the 30% Rebate in the Mid Year Economic and Fiscal Outlook.) What is your participation rate assumption? What about premium increases?

Answer:

The answer to this question was provided as part of the answer to Senate Estimates Written Question on Notice Number E039.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E099**

Topic: PHI

Hansard Page: CA64

Senator Evans asked:

What about premium increases

Answer:

The answer to this question has been incorporated into the response to Question E039.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E044**

Topic: HARDSHIP PROVISIONS UNDER LIFETIME HEALTH COVER

Written Question on Notice

Senator Christopher Evans asked:

(a) How many applications has the Department received for consideration under the hardship provisions for Lifetime Health Cover?

(b) Has the Department received a lot of queries about this matter by phone and letters, which are not formal applications?

(c) What process has been followed in considering these applications and what role does the Minister play in making a decision on each application?

(d) How many of the applications and enquires received have been ruled ineligible to be considered because of the requirement that the person has to have previously held private health insurance?

(e) How many of these applications have been granted and how many have been refused?

Answer:

(a) As of 24 November 2000 a total of 2,383 applications had been received by the Department for consideration under the hardship provisions for Lifetime Health Cover.

(b) Yes.

(c) Under Clause 10 of Schedule 2 of the *National Health Act 1953*, the Minister for Health and Aged Care must determine that a person is to be treated as having had hospital cover on 30 June 1999 and 1 July 2000 if the person applies to the Minister before 1 July 2002 and he is satisfied that one or more of the circumstances specified in the National Health (Lifetime Health Cover) Regulations 2000 apply to the person.

On 26 May 2000 the Minister signed an instrument of delegation to enable two departmental officers to exercise power to make hardship determinations in

relation to Lifetime Health Cover. The Minister has not personally been involved in making determinations in relation to applications under the hardship provisions.

The Regulations specify three criteria under the hardship provision:

- financial difficulty;
- exceptional circumstances; and
- migrants.

Only one of these criteria needs to be met to be successful under the hardship provision.

Subclause 10(3) of Schedule 2 of the Act provides that the application must be:

- made before 1 July 2002; and
- in the form approved by the Minister; and
- lodged in the manner approved by the Minister.

On 2 June 2000 the Minister approved the following form of application:

- applications must be in writing;
- the applicant must specify that he or she is seeking an exception to the general rules on the basis of hardship and must address one of the criteria contained in the Regulations;
- applications must be accompanied by documentary evidence necessary to satisfy the Minister that one or more of the circumstances specified in the Regulations applies.

Once the Department has received an application the documentary evidence is assessed to establish if it is sufficient for the delegate to determine that the applicant has satisfied one of the three criteria specified in the regulations under the hardship provision. Once the delegate has made a decision, the applicant is advised in writing of the outcome.

Where there is insufficient documentary evidence to make a determination the Department is writing to each such applicant to advise them of the additional documentary evidence that must be supplied. Applicants are also advised that they must forward the additional evidence within 90 days of the date of this letter to allow the application to be processed.

(d) All applications received by the Department are considered by the delegate. If an applicant does not meet the required criteria the delegate must refuse to make a determination that the person is to be treated as having hospital cover on 30 June 1999. As at 24 November 2000 the delegate had refused to make two such determinations in relation to applications because of the requirement that the person had to have previously held private health insurance.

The delegate cannot refuse to make a determination where there has not been an application (such as where a person simply enquires about the hardship provisions).

As of 24 November 2000 there had been 1,081 determinations and three refusals to make a determination.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E061**

Topic: HEALTH FUNDS BY ELECTORATE

Hansard Page: CA 67-69

Senator Evans asked:

(a) When did the Department collate figures on the membership of health funds by federal electorate?

(b) Did the Minister or the Minister's Office request the department to do a breakdown on an electorate by electorate basis?

(c) Were the numbers crunched by the Department or by the HIC?

(d) What are the rules governing the HIC providing that information to the Department?

(e) What protocols are in place for use of that information?

(f) How do you make a decision when postcode boundaries cross electoral boundaries - can you give a description of how that works, what sort of techniques are used to translate postcode data into electorate data?

Answer:

(a) High level electorate statistics based on quarterly data updates were collated in June, July and September 2000.

(b) An initial request for electorate information was received from the Minister's Office. At that time administrative data on the 30% Rebate was not available and the Minister's Office was directed to the Australian Health Insurance Association as a potential source of information. When administrative data became available subsequently, the Department provided electorate statistics on:
   1) the number of private health insurance policies by electorate; and
   2) the number of people registered through HIC for the 30% Rebate in an aggregate, confidentialised form showing which electorates had low, medium or high levels of private health insurance but not providing actual participation percentages for any individual electorate.

We have been advised that all information used by the Minister's Office on actual participation rates within particular electorates was provided by the Australian Health Insurance Association to the Minister's office..

(c) The HIC provided information aggregated by postcode to the Department. The Department converted the postcode statistics to electorate statistics.

(d) Administrative arrangements outlined in the Schedule to the Strategic Partnership Agreement between the HIC and The Department of Health and Aged Care (the Department) govern the provision of information by the HIC to the Department about the 30% Rebate. Statistics on the 30% Rebate provided by the HIC to the Department include, the number of private health insurance policies, and the number of people covered, by type of cover (e.g. A = Ancillary, H = Hospital, B= Both (combined hospital and ancillary cover)), for all funds. This information is grouped by postcode. These aggregated, de-identified statistics assist in monitoring general trends and policy development for this program.

(e) The Department is currently consulting with HIC to develop protocols for wider public dissemination of this information both by postcode and by electorate (as part of the Department's electorate profiles that are publicly available on the Internet). Any dissemination of this information will be in line with general Government agency confidentiality requirements whereby all information is aggregated to a high level and small cell sizes are deleted or merged to protect the confidentiality of individuals and providers.

(f) The postcode data were converted to electorates using a concordance based on the 1996 census.

Concordance files to do this conversion are produced by the Department and are also available from to the public the Australian Bureau of Statistics (ABS – Catalogue number 1253.0, "Postcode to Statistical Local Area Concordance Australia".

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E116**

Topic: INFORMATION ON HEALTH FUND MEMBERSHIP BY ELECTORATE

Hansard Page: CA 70

Senator West asked:

> **Can you provide the committee with the data that you provided to the minister's office?**

Answer:

The data provided to the minister's office is attached.

Coverage Comparison, Number of Policies (31 March 2000 data)

HIC

Type	NSW/ACT	NT	QLD	SA	TAS	VIC	WA	Grand Total
Ancillary only	198706	2173	61823	68803	11604	66542	82560	492211
Both	671876	13663	302910	169219	55011	360113	196164	1768956
Hospital Only	228583	2387	134712	38898	12779	309266	16735	743360
Grand Total	1099165	18223	499445	276920	79394	735921	295459	3004527
Hospital	**900459**	**16050**	**437622**	**208117**	**67790**	**669379**	**212899**	**2512316**

PHIAC

Type	NSW/ACT	NT	QLD	SA	TAS	VIC	WA	Grand Total
Ancillary only	274517	2635	74489	80474	14523	79787	192165	718590
Both	814573	17926	358585	200427	64685	413411	290795	2160402
Hospital Only	242056	3261	141986	41186	13833	314107	19299	775728
Grand Total	1331146	23822	575060	322087	93041	807305	502259	3654720
Hospital	**1056629**	**21187**	**500571**	**241613**	**78518**	**727518**	**310094**	**2936130**

HIC Coverage (% of PHIAC)

Type	NSW/ACT	NT	QLD	SA	TAS	VIC	WA	Grand Total
Ancillary only	72.4%	82.5%	83.0%	85.5%	79.9%	83.4%	43.0%	68.5%
Both	82.5%	76.2%	84.5%	84.4%	85.0%	87.1%	67.5%	81.9%
Hospital Only	94.4%	73.2%	94.9%	94.4%	92.4%	98.5%	86.7%	95.8%
Grand Total	82.6%	76.5%	86.9%	86.0%	85.3%	91.2%	58.8%	82.2%
Hospital	**85.2%**	**75.8%**	**87.4%**	**86.1%**	**86.3%**	**92.0%**	**68.7%**	**85.6%**

Date	CED	CED Name	Type of Cover	Policies
31-Mar-00	101	Banks	A	2659
31-Mar-00	101	Banks	B	13304
31-Mar-00	101	Banks	H	4907
31-Mar-00	102	Barton	A	2842
31-Mar-00	102	Barton	B	15032
31-Mar-00	102	Barton	H	5109
31-Mar-00	103	Bennelong	A	3341
31-Mar-00	103	Bennelong	B	19237
31-Mar-00	103	Bennelong	H	6003
31-Mar-00	104	Berowra	A	3260
31-Mar-00	104	Berowra	B	22486
31-Mar-00	104	Berowra	H	6062
31-Mar-00	105	Blaxland	A	3927
31-Mar-00	105	Blaxland	B	8706
31-Mar-00	105	Blaxland	H	3388
31-Mar-00	106	Bradfield	A	2298
31-Mar-00	106	Bradfield	B	27403
31-Mar-00	106	Bradfield	H	5705
31-Mar-00	107	Calare	A	4681
31-Mar-00	107	Calare	B	8257
31-Mar-00	107	Calare	H	3223
31-Mar-00	108	Charlton	A	3368
31-Mar-00	108	Charlton	B	12350
31-Mar-00	108	Charlton	H	3993
31-Mar-00	109	Chifley	A	2238
31-Mar-00	109	Chifley	B	5633
31-Mar-00	109	Chifley	H	1739
31-Mar-00	110	Cook	A	2163
31-Mar-00	110	Cook	B	18935
31-Mar-00	110	Cook	H	6750
31-Mar-00	111	Cowper	A	6143
31-Mar-00	111	Cowper	B	6016
31-Mar-00	111	Cowper	H	3382
31-Mar-00	112	Cunningham	A	3462
31-Mar-00	112	Cunningham	B	11700
31-Mar-00	112	Cunninam	H	3423
31-Mar-00	113	Dobell	A	2941
31-Mar-00	113	Dobell	B	10379
31-Mar-00	113	Dobell	H	5590
31-Mar-00	114	Eden-Monaro	A	5805
31-Mar-00	114	Eden-Monaro	B	6756
31-Mar-00	114	Eden-Monaro	H	3576
31-Mar-00	115	Farrer	A	5982
31-Mar-00	115	Farrer	B	7702
31-Mar-00	115	Farrer	H	5157
31-Mar-00	116	Fowler	A	4394
31-Mar-00	116	Fowler	B	7096
31-Mar-00	116	Fowler	H	2308
31-Mar-00	117	Gilmore	A	3730
31-Mar-00	117	Gilmore	B	8878
31-Mar-00	117	Gilmore	H	4882

31-Mar-00	118	Grayndler	A	3866
31-Mar-00	118	Grayndler	B	12241
31-Mar-00	118	Grayndler	H	3351
31-Mar-00	119	Greenway	A	2720
31-Mar-00	119	Greenway	B	10670
31-Mar-00	119	Greenway	H	3458
31-Mar-00	120	Gwydir	A	4413
31-Mar-00	120	Gwydir	B	7469
31-Mar-00	120	Gwydir	H	2890
31-Mar-00	121	Hughes	A	2918
31-Mar-00	121	Hughes	B	16853
31-Mar-00	121	Hughes	H	5262
31-Mar-00	122	Hume	A	4748
31-Mar-00	122	Hume	B	7082
31-Mar-00	122	Hume	H	3350
31-Mar-00	123	Hunter	A	3536
31-Mar-00	123	Hunter	B	9773
31-Mar-00	123	Hunter	H	2632
31-Mar-00	124	Kingsford-Smith	A	3791
31-Mar-00	124	Kingsford-Smith	B	15857
31-Mar-00	124	Kingsford-Smith	H	3836
31-Mar-00	125	Lindsay	A	2794
31-Mar-00	125	Lindsay	B	9982
31-Mar-00	125	Lindsay	H	2907
31-Mar-00	126	Lowe	A	3040
31-Mar-00	126	Lowe	B	17724
31-Mar-00	126	Lowe	H	5434
31-Mar-00	127	Lyne	A	3644
31-Mar-00	127	Lyne	B	8551
31-Mar-00	127	Lyne	H	5589
31-Mar-00	128	Macarthur	A	3570
31-Mar-00	128	Macarthur	B	11981
31-Mar-00	128	Macarthur	H	4034
31-Mar-00	129	Mackellar	A	2796
31-Mar-00	129	Mackellar	B	19325
31-Mar-00	129	Mackellar	H	5183
31-Mar-00	130	Macquarie	A	2836
31-Mar-00	130	Macquarie	B	10516
31-Mar-00	130	Macquarie	H	3373
31-Mar-00	131	Mitchell	A	2621
31-Mar-00	131	Mitchell	B	20123
31-Mar-00	131	Mitchell	H	5606
31-Mar-00	132	Newcastle	A	2957
31-Mar-00	132	Newcastle	B	12475
31-Mar-00	132	Newcastle	H	3502
31-Mar-00	133	New England	A	6713
31-Mar-00	133	New England	B	7632
31-Mar-00	133	New England	H	3344
31-Mar-00	134	North Sydney	A	3496
31-Mar-00	134	North Sydney	B	28771
31-Mar-00	134	North Sydney	H	6157
31-Mar-00	135	Page	A	6594
31-Mar-00	135	Page	B	6481

31-Mar-00	135	Page	H	3417
31-Mar-00	136	Parkes	A	4370
31-Mar-00	136	Parkes	B	8316
31-Mar-00	136	Parkes	H	4515
31-Mar-00	137	Parramatta	A	2929
31-Mar-00	137	Parramatta	B	14427
31-Mar-00	137	Parramatta	H	4570
31-Mar-00	138	Paterson	A	3208
31-Mar-00	138	Paterson	B	9150
31-Mar-00	138	Paterson	H	3476
31-Mar-00	139	Prospect	A	2946
31-Mar-00	139	Prospect	B	7598
31-Mar-00	139	Prospect	H	2884
31-Mar-00	140	Reid	A	3429
31-Mar-00	140	Reid	B	8472
31-Mar-00	140	Reid	H	3139
31-Mar-00	141	Richmond	A	5264
31-Mar-00	141	Richmond	B	8308
31-Mar-00	141	Richmond	H	5618
31-Mar-00	142	Riverina	A	6006
31-Mar-00	142	Riverina	B	8891
31-Mar-00	142	Riverina	H	5592
31-Mar-00	143	Robertson	A	2485
31-Mar-00	143	Robertson	B	11234
31-Mar-00	143	Robertson	H	6426
31-Mar-00	144	Shortland	A	3016
31-Mar-00	144	Shortland	B	10540
31-Mar-00	144	Shortland	H	3731
31-Mar-00	145	Sydney	A	4284
31-Mar-00	145	Sydney	B	19953
31-Mar-00	145	Sydney	H	4135
31-Mar-00	146	Throsby	A	3640
31-Mar-00	146	Throsby	B	8126
31-Mar-00	146	Throsby	H	2131
31-Mar-00	147	Warringah	A	2685
31-Mar-00	147	Warringah	B	22640
31-Mar-00	147	Warringah	H	5386
31-Mar-00	148	Watson	A	3570
31-Mar-00	148	Watson	B	10784
31-Mar-00	148	Watson	H	3917
31-Mar-00	149	Wentworth	A	3770
31-Mar-00	149	Wentworth	B	26629
31-Mar-00	149	Wentworth	H	4388
31-Mar-00	150	Werriwa	A	2654
31-Mar-00	150	Werriwa	B	8201
31-Mar-00	150	Werriwa	H	2373
31-Mar-00	199	NSW Off-shore Areas & Migratory	A	1
31-Mar-00	199	NSW Off-shore Areas & Migratory	B	3
31-Mar-00	199	NSW Off-shore Areas & Migratory	H	1
31-Mar-00	201	Aston	A	1939
31-Mar-00	201	Aston	B	11166
31-Mar-00	201	Aston	H	9191
31-Mar-00	202	Ballarat	A	1041

31-Mar-00	202	Ballarat	B	8808
31-Mar-00	202	Ballarat	H	9865
31-Mar-00	203	Batman	A	1184
31-Mar-00	203	Batman	B	7085
31-Mar-00	203	Batman	H	9896
31-Mar-00	204	Bendigo	A	959
31-Mar-00	204	Bendigo	B	6608
31-Mar-00	204	Bendigo	H	8985
31-Mar-00	205	Bruce	A	1876
31-Mar-00	205	Bruce	B	11135
31-Mar-00	205	Bruce	H	8813
31-Mar-00	206	Burke	A	1356
31-Mar-00	206	Burke	B	7095
31-Mar-00	206	Burke	H	6195
31-Mar-00	207	Calwell	A	1261
31-Mar-00	207	Calwell	B	6644
31-Mar-00	207	Calwell	H	6635
31-Mar-00	208	Casey	A	1473
31-Mar-00	208	Casey	B	8544
31-Mar-00	208	Casey	H	8810
31-Mar-00	209	Chisholm	A	1818
31-Mar-00	209	Chisholm	B	13440
31-Mar-00	209	Chisholm	H	11996
31-Mar-00	210	Coragamite	A	2900
31-Mar-00	210	Coragamite	B	11835
31-Mar-00	210	Coragamite	H	8090
31-Mar-00	211	Corio	A	3656
31-Mar-00	211	Corio	B	11625
31-Mar-00	211	Corio	H	7043
31-Mar-00	212	Deakin	A	1758
31-Mar-00	212	Deakin	B	12078
31-Mar-00	212	Deakin	H	11603
31-Mar-00	213	Dunkley	A	1711
31-Mar-00	213	Dunkley	B	8370
31-Mar-00	213	Dunkley	H	8224
31-Mar-00	214	Flinders	A	1474
31-Mar-00	214	Flinders	B	7656
31-Mar-00	214	Flinders	H	8939
31-Mar-00	215	Gellibrand	A	1377
31-Mar-00	215	Gellibrand	B	6110
31-Mar-00	215	Gellibrand	H	5720
31-Mar-00	216	Gippsland	A	1700
31-Mar-00	216	Gippsland	B	4467
31-Mar-00	216	Gippsland	H	3838
31-Mar-00	217	Goldstein	A	2238
31-Mar-00	217	Goldstein	B	18918
31-Mar-00	217	Goldstein	H	13223
31-Mar-00	218	Higgins	A	1920
31-Mar-00	218	Higgins	B	20130
31-Mar-00	218	Higgins	H	11712
31-Mar-00	219	Holt	A	1844
31-Mar-00	219	Holt	B	6336
31-Mar-00	219	Holt	H	5390

31-Mar-00	220	Hotham	A	2134
31-Mar-00	220	Hotham	B	9251
31-Mar-00	220	Hotham	H	8731
31-Mar-00	221	Indi	A	1831
31-Mar-00	221	Indi	B	5364
31-Mar-00	221	Indi	H	5492
31-Mar-00	222	Isaacs	A	1734
31-Mar-00	222	Isaacs	B	7835
31-Mar-00	222	Isaacs	H	7560
31-Mar-00	223	Jagajaga	A	1420
31-Mar-00	223	Jagajaga	B	12145
31-Mar-00	223	Jagajaga	H	11836
31-Mar-00	224	Kooyong	A	1591
31-Mar-00	224	Kooyong	B	19639
31-Mar-00	224	Kooyong	H	12770
31-Mar-00	225	Lalor	A	1763
31-Mar-00	225	Lalor	B	6220
31-Mar-00	225	Lalor	H	4695
31-Mar-00	226	Latrobe	A	1777
31-Mar-00	226	Latrobe	B	8417
31-Mar-00	226	Latrobe	H	7601
31-Mar-00	227	Mallee	A	2599
31-Mar-00	227	Mallee	B	7832
31-Mar-00	227	Mallee	H	5586
31-Mar-00	228	Maribyrnong	A	1397
31-Mar-00	228	Maribyrnong	B	7446
31-Mar-00	228	Maribyrnong	H	7891
31-Mar-00	229	McEwan	A	1182
31-Mar-00	229	McEwan	B	7116
31-Mar-00	229	McEwan	H	7304
31-Mar-00	230	McMillan	A	2720
31-Mar-00	230	McMillan	B	6861
31-Mar-00	230	McMillan	H	3534
31-Mar-00	231	Melbourne	A	1792
31-Mar-00	231	Melbourne	B	12186
31-Mar-00	231	Melbourne	H	8267
31-Mar-00	232	Melbourne Ports	A	2857
31-Mar-00	232	Melbourne Ports	B	17370
31-Mar-00	232	Melbourne Ports	H	8818
31-Mar-00	233	Menzies	A	1648
31-Mar-00	233	Menzies	B	14428
31-Mar-00	233	Menzies	H	11327
31-Mar-00	234	Murray	A	1107
31-Mar-00	234	Murray	B	6531
31-Mar-00	234	Murray	H	7966
31-Mar-00	235	Scullin	A	1056
31-Mar-00	235	Scullin	B	6610
31-Mar-00	235	Scullin	H	7544
31-Mar-00	236	Wannon	A	2536
31-Mar-00	236	Wannon	B	4960
31-Mar-00	236	Wannon	H	5279
31-Mar-00	237	Wills	A	1309
31-Mar-00	237	Wills	B	9589

31-Mar-00	237	Wills	H	11394
31-Mar-00	299	VIC Off-shore Areas & Migratory	A	18
31-Mar-00	299	VIC Off-shore Areas & Migratory	B	8
31-Mar-00	301	Bowman	A	3823
31-Mar-00	301	Bowman	B	10117
31-Mar-00	301	Bowman	H	3873
31-Mar-00	302	Brisbane	A	3663
31-Mar-00	302	Brisbane	B	17011
31-Mar-00	302	Brisbane	H	5174
31-Mar-00	303	Capricornia	A	890
31-Mar-00	303	Capricornia	B	14456
31-Mar-00	303	Capricornia	H	5884
31-Mar-00	304	Dawson	A	1296
31-Mar-00	304	Dawson	B	13128
31-Mar-00	304	Dawson	H	5655
31-Mar-00	305	Dickson	A	3535
31-Mar-00	305	Dickson	B	12790
31-Mar-00	305	Dickson	H	4149
31-Mar-00	306	Fadden	A	2906
31-Mar-00	306	Fadden	B	10652
31-Mar-00	306	Fadden	H	4939
31-Mar-00	307	Fairfax	A	2964
31-Mar-00	307	Fairfax	B	10505
31-Mar-00	307	Fairfax	H	5016
31-Mar-00	308	Fisher	A	2444
31-Mar-00	308	Fisher	B	9450
31-Mar-00	308	Fisher	H	4802
31-Mar-00	309	Forde	A	2135
31-Mar-00	309	Forde	B	6266
31-Mar-00	309	Forde	H	3217
31-Mar-00	310	Griffith	A	3483
31-Mar-00	310	Griffith	B	14698
31-Mar-00	310	Griffith	H	5212
31-Mar-00	311	Groom	A	1542
31-Mar-00	311	Groom	B	14921
31-Mar-00	311	Groom	H	8233
31-Mar-00	312	Herbert	A	1475
31-Mar-00	312	Herbert	B	11716
31-Mar-00	312	Herbert	H	6274
31-Mar-00	313	Hinkler	A	1438
31-Mar-00	313	Hinkler	B	11540
31-Mar-00	313	Hinkler	H	5983
31-Mar-00	314	Kennedy	A	847
31-Mar-00	314	Kennedy	B	9871
31-Mar-00	314	Kennedy	H	6211
31-Mar-00	315	Leichhardt	A	1812
31-Mar-00	315	Leichhardt	B	10441
31-Mar-00	315	Leichhardt	H	4521
31-Mar-00	316	Lilley	A	3068
31-Mar-00	316	Lilley	B	14335
31-Mar-00	316	Lilley	H	4604
31-Mar-00	317	Longman	A	2246
31-Mar-00	317	Longman	B	7144

31-Mar-00	317	Longman	H	3360
31-Mar-00	318	Maranoa	A	936
31-Mar-00	318	Maranoa	B	12050
31-Mar-00	318	Maranoa	H	6372
31-Mar-00	319	McPherson	A	2901
31-Mar-00	319	McPherson	B	12387
31-Mar-00	319	McPherson	H	7592
31-Mar-00	320	Moncrieff	A	2567
31-Mar-00	320	Moncrieff	B	12075
31-Mar-00	320	Moncrieff	H	6321
31-Mar-00	321	Moreton	A	3566
31-Mar-00	321	Moreton	B	13638
31-Mar-00	321	Moreton	H	4705
31-Mar-00	322	Oxley	A	1789
31-Mar-00	322	Oxley	B	7285
31-Mar-00	322	Oxley	H	4044
31-Mar-00	323	Petrie	A	2628
31-Mar-00	323	Petrie	B	9632
31-Mar-00	323	Petrie	H	4032
31-Mar-00	324	Rankin	A	2657
31-Mar-00	324	Rankin	B	6638
31-Mar-00	324	Rankin	H	2457
31-Mar-00	325	Ryan	A	3101
31-Mar-00	325	Ryan	B	19881
31-Mar-00	325	Ryan	H	5643
31-Mar-00	326	Wide Bay	A	1477
31-Mar-00	326	Wide Bay	B	7619
31-Mar-00	326	Wide Bay	H	5482
31-Mar-00	399	QLD Off-shore Areas & Migratory	A	1
31-Mar-00	399	QLD Off-shore Areas & Migratory	B	5
31-Mar-00	399	QLD Off-shore Areas & Migratory	H	2
31-Mar-00	401	Adelaide	A	4853
31-Mar-00	401	Adelaide	B	18438
31-Mar-00	401	Adelaide	H	4183
31-Mar-00	402	Barker	A	6717
31-Mar-00	402	Barker	B	9213
31-Mar-00	402	Barker	H	1886
31-Mar-00	403	Bonython	A	5100
31-Mar-00	403	Bonython	B	7098
31-Mar-00	403	Bonython	H	1666
31-Mar-00	404	Boothby	A	5167
31-Mar-00	404	Boothby	B	19356
31-Mar-00	404	Boothby	H	4570
31-Mar-00	405	Grey	A	5770
31-Mar-00	405	Grey	B	8461
31-Mar-00	405	Grey	H	1585
31-Mar-00	406	Hindmarsh	A	5037
31-Mar-00	406	Hindmarsh	B	19012
31-Mar-00	406	Hindmarsh	H	5218
31-Mar-00	407	Kingston	A	7605
31-Mar-00	407	Kingston	B	10448
31-Mar-00	407	Kingston	H	2244
31-Mar-00	408	Makin	A	7283

31-Mar-00	408	Makin	B	13999
31-Mar-00	408	Makin	H	2864
31-Mar-00	409	Mayo	A	6483
31-Mar-00	409	Mayo	B	18235
31-Mar-00	409	Mayo	H	3702
31-Mar-00	410	Port Adelaide	A	4666
31-Mar-00	410	Port Adelaide	B	12902
31-Mar-00	410	Port Adelaide	H	3801
31-Mar-00	411	Sturt	A	4382
31-Mar-00	411	Sturt	B	20660
31-Mar-00	411	Sturt	H	4506
31-Mar-00	412	Wakefield	A	5631
31-Mar-00	412	Wakefield	B	10778
31-Mar-00	412	Wakefield	H	2561
31-Mar-00	501	Brand	A	6779
31-Mar-00	501	Brand	B	8439
31-Mar-00	501	Brand	H	1075
31-Mar-00	502	Canning	A	6340
31-Mar-00	502	Canning	B	9496
31-Mar-00	502	Canning	H	902
31-Mar-00	503	Cowan	A	6159
31-Mar-00	503	Cowan	B	11625
31-Mar-00	503	Cowan	H	818
31-Mar-00	504	Curtin	A	5040
31-Mar-00	504	Curtin	B	21741
31-Mar-00	504	Curtin	H	2020
31-Mar-00	505	Forrest	A	4278
31-Mar-00	505	Forrest	B	9396
31-Mar-00	505	Forrest	H	776
31-Mar-00	506	Fremantle	A	5759
31-Mar-00	506	Fremantle	B	16976
31-Mar-00	506	Fremantle	H	1726
31-Mar-00	507	Kalgoorlie	A	2895
31-Mar-00	507	Kalgoorlie	B	9894
31-Mar-00	507	Kalgoorlie	H	571
31-Mar-00	508	Moore	A	7042
31-Mar-00	508	Moore	B	12403
31-Mar-00	508	Moore	H	1024
31-Mar-00	509	O'Connor	A	2807
31-Mar-00	509	O'Connor	B	12564
31-Mar-00	509	O'Connor	H	725
31-Mar-00	510	Pearce	A	6281
31-Mar-00	510	Pearce	B	12043
31-Mar-00	510	Pearce	H	915
31-Mar-00	511	Perth	A	6975
31-Mar-00	511	Perth	B	13321
31-Mar-00	511	Perth	H	1284
31-Mar-00	512	Stirling	A	6497
31-Mar-00	512	Stirling	B	15820
31-Mar-00	512	Stirling	H	1223
31-Mar-00	513	Swan	A	6992
31-Mar-00	513	Swan	B	15171
31-Mar-00	513	Swan	H	1432

31-Mar-00	514	Tangney	A	6008
31-Mar-00	514	Tangney	B	19264
31-Mar-00	514	Tangney	H	1641
31-Mar-00	599	WA Off-shore Areas & Migratory	B	3
31-Mar-00	599	WA Off-shore Areas & Migratory	H	1
31-Mar-00	601	Bass	A	2079
31-Mar-00	601	Bass	B	9986
31-Mar-00	601	Bass	H	3111
31-Mar-00	602	Braddon	A	3692
31-Mar-00	602	Braddon	B	5497
31-Mar-00	602	Braddon	H	1183
31-Mar-00	603	Denison	A	1964
31-Mar-00	603	Denison	B	15824
31-Mar-00	603	Denison	H	3008
31-Mar-00	604	Franklin	A	2038
31-Mar-00	604	Franklin	B	14512
31-Mar-00	604	Franklin	H	2916
31-Mar-00	605	Lyons	A	1779
31-Mar-00	605	Lyons	B	8846
31-Mar-00	605	Lyons	H	2507
31-Mar-00	701	Northern Territory	A	1989
31-Mar-00	701	Northern Territory	B	12346
31-Mar-00	701	Northern Territory	H	2187
31-Mar-00	801	Canberra	A	2852
31-Mar-00	801	Canberra	B	12015
31-Mar-00	801	Canberra	H	4891
31-Mar-00	802	Fraser	A	3248
31-Mar-00	802	Fraser	B	9762
31-Mar-00	802	Fraser	H	3343
31-Mar-00	803	Namadgi	A	3011
31-Mar-00	803	Namadgi	B	8926
31-Mar-00	803	Namadgi	H	3186
31-Mar-00	901	Incl. in Northern Territory 701	A	10
31-Mar-00	901	Incl. in Northern Territory 701	B	37
31-Mar-00	901	Incl. in Northern Territory 701	H	8
31-Mar-00	902	Incl. in Fraser - ACT 802	A	21
31-Mar-00	902	Incl. in Fraser - ACT 802	B	45
31-Mar-00	902	Incl. in Fraser - ACT 802	H	26
				2955838

Postcode Data Total **2986897**
Percentage Loss **1.0%**

Level of Hospital Cover by Electorate, March 2000

This report compares the proportion of people with hospital insurance by electorate. "High" and "Low" values were determined based on estimates using 30% health insurance rebate registration data.

Cut-off values are based on the standard deviation of the estimated proportion by electorate.
Very Low: <15.6%
Low: 15.6%-26.6%
Average: 26.6%-37.6% (national average =32.2%)
High: 37.6%-48.6%
Very High: >48.6%

State Name	*Electorate*	*Level of Cover*
ACT		
	Canberra	Average
	Fraser	Average
NSW		
	Banks	High
	Barton	Average
	Bennelong	High
	Berowra	Very High
	Blaxland	Low
	Bradfield	Very High
	Calare	Low
	Charlton	Average
	Chifley	Very Low
	Cook	Very High
	Cowper	Low
	Cunningham	Average
	Dobell	Average
	Eden-Monaro	Low
	Farrer	Average
	Fowler	Very Low
	Gilmore	Average
	Grayndler	Low
	Greenway	Average
	Gwydir	Low
	Hughes	High
	Hume	Low
	Hunter	Average
	Kingsford-Smith	Average
	Lindsay	Low
	Lowe	High
	Lyne	Low
	Macarthur	Average
	Mackellar	High
	Macquarie	Average
	Mitchell	Very High
	New England	Low
	Newcastle	Average
	North Sydney	Very High
	Page	Low
	Parkes	Average
	Parramatta	Average
	Paterson	Low
	Prospect	Low

State Name	Electorate	Level of Cover
NSW		
	Reid	Low
	Richmond	Low
	Riverina	Average
	Robertson	Average
	Shortland	Average
	Sydney	Average
	Throsby	Low
	Warringah	Very High
	Watson	Low
	Wentworth	Very High
	Werriwa	Low
NT		
	Northern Territory	Low
QLD		
	Blair	Average
	Bowman	Average
	Brisbane	Average
	Capricornia	High
	Dawson	Average
	Dickson	Average
	Fadden	Average
	Fairfax	Low
	Fisher	Average
	Forde	Low
	Griffith	Average
	Groom	High
	Herbert	Average
	Hinkler	Average
	Kennedy	Average
	Leichhardt	Low
	Lilley	Average
	Longman	Low
	Maranoa	Average
	Mcpherson	Average
	Moncrieff	Average
	Moreton	Average
	Oxley	Low
	Petrie	Low
	Rankin	Low
	Ryan	Very High
	Wide Bay	Low
SA		
	Adelaide	High
	Barker	Low
	Bonython	Low
	Boothby	Very High
	Grey	Low
	Hindmarsh	High
	Kingston	Low
	Makin	Average
	Mayo	High
	Port Adelaide	Average
	Sturt	Very High
	Wakefield	Low

State Name	Electorate	Level of Cover
TAS		
	Bass	Average
	Braddon	Low
	Denison	High
	Franklin	High
	Lyons	Average
VIC		
	Aston	High
	Ballarat	Average
	Batman	Low
	Bendigo	Average
	Bruce	Average
	Burke	Low
	Calwell	Low
	Casey	Average
	Chisholm	High
	Corangamite	High
	Corio	Average
	Deakin	High
	Dunkley	Average
	Flinders	Average
	Gellibrand	Low
	Gippsland	Low
	Goldstein	Very High
	Higgins	Very High
	Holt	Low
	Hotham	Average
	Indi	Low
	Isaacs	Low
	Jagajaga	High
	Kooyong	Very High
	La Trobe	Average
	Lalor	Low
	Mallee	Low
	Maribyrnong	Low
	Mcewen	Average
	Mcmillan	Low
	Melbourne	Low
	Melbourne Ports	High
	Menzies	Very High
	Murray	Average
	Scullin	Low
	Wannon	Low
	Wills	Average
WA		
	Brand	Low
	Canning	Average
	Cowan	Average
	Curtin	Very High
	Forrest	Low
	Fremantle	High
	Kalgoorlie	Low
	Moore	Average
	O'Connor	Average
	Pearce	Average
	Perth	Average
	Stirling	High

State Name	*Electorate*	*Level of Cover*
WA		
	Swan	Average
	Tangney	Very High

Level of Hospital Cover by Electorate, July 2000

This report compares the proportion of people with hospital insurance by electorate. "High" and "Low" values were determined based on estimates using 30% health insurance rebate registration data.

Cut-off values are based on the spread of the estimated proportion by electorate in March 2000.
Very Low: <15.6%
Low: 15.6%-26.6%
Average: 26.6%-37.6% (national average =32.2%)
High: 37.6%-48.6%
Very High: >48.6%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
ACT				
Canberra				
	31/03/2000	Average		
	30/06/2000	High	6,528	5%
Fraser				
	31/03/2000	Average		
	30/06/2000	High	8,055	6%
NSW				
Banks				
	31/03/2000	High		
	30/06/2000	High	3,956	4%
Barton				
	31/03/2000	Average		
	30/06/2000	High	5,044	5%
Bennelong				
	31/03/2000	High		
	30/06/2000	Very High	5,586	5%
Berowra				
	31/03/2000	Very High		
	30/06/2000	Very High	6,088	6%
Blaxland				
	31/03/2000	Low		
	30/06/2000	Low	3,665	3%
Bradfield				
	31/03/2000	Very High		
	30/06/2000	Very High	4,230	4%
Calare				
	31/03/2000	Low		
	30/06/2000	Average	4,399	4%
Charlton				
	31/03/2000	Average		
	30/06/2000	Average	5,328	5%
Chifley				
	31/03/2000	Very Low		
	30/06/2000	Low	5,000	4%
Cook				
	31/03/2000	Very High		
	30/06/2000	Very High	4,999	5%
Cowper				
	31/03/2000	Low		
	30/06/2000	Low	2,426	2%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
NSW				
Cunningham				
	31/03/2000	Average		
	30/06/2000	Average	4,371	5%
Dobell				
	31/03/2000	Average		
	30/06/2000	Average	4,593	4%
Eden-Monaro				
	31/03/2000	Low		
	30/06/2000	Low	2,484	3%
Farrer				
	31/03/2000	Average		
	30/06/2000	Average	4,565	5%
Fowler				
	31/03/2000	Very Low		
	30/06/2000	Low	4,229	3%
Gilmore				
	31/03/2000	Average		
	30/06/2000	Average	2,980	3%
Grayndler				
	31/03/2000	Low		
	30/06/2000	Average	4,553	4%
Greenway				
	31/03/2000	Average		
	30/06/2000	Average	6,519	6%
Gwydir				
	31/03/2000	Low		
	30/06/2000	Average	2,596	3%
Hughes				
	31/03/2000	High		
	30/06/2000	Very High	6,031	5%
Hume				
	31/03/2000	Low		
	30/06/2000	Average	2,389	3%
Hunter				
	31/03/2000	Average		
	30/06/2000	Average	4,263	4%
Kingsford-Smith				
	31/03/2000	Average		
	30/06/2000	High	5,474	5%
Lindsay				
	31/03/2000	Low		
	30/06/2000	Average	6,678	6%
Lowe				
	31/03/2000	High		
	30/06/2000	High	5,084	5%
Lyne				
	31/03/2000	Low		
	30/06/2000	Average	2,591	3%
Macarthur				
	31/03/2000	Average		
	30/06/2000	Average	6,834	5%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
NSW				
Mackellar				
	31/03/2000	High		
	30/06/2000	Very High	5,426	5%
Macquarie				
	31/03/2000	Average		
	30/06/2000	Average	4,251	4%
Mitchell				
	31/03/2000	Very High		
	30/06/2000	Very High	5,836	5%
New England				
	31/03/2000	Low		
	30/06/2000	Average	3,897	4%
Newcastle				
	31/03/2000	Average		
	30/06/2000	Average	4,000	4%
North Sydney				
	31/03/2000	Very High		
	30/06/2000	Very High	5,924	5%
Page				
	31/03/2000	Low		
	30/06/2000	Low	2,626	3%
Parkes				
	31/03/2000	Average		
	30/06/2000	Average	3,845	4%
Parramatta				
	31/03/2000	Average		
	30/06/2000	High	4,987	5%
Paterson				
	31/03/2000	Low		
	30/06/2000	Average	3,477	3%
Prospect				
	31/03/2000	Low		
	30/06/2000	Low	3,616	3%
Reid				
	31/03/2000	Low		
	30/06/2000	Low	4,236	3%
Richmond				
	31/03/2000	Low		
	30/06/2000	Low	4,050	4%
Riverina				
	31/03/2000	Average		
	30/06/2000	Average	3,574	3%
Robertson				
	31/03/2000	Average		
	30/06/2000	High	4,941	5%
Shortland				
	31/03/2000	Average		
	30/06/2000	Average	4,602	5%
Sydney				
	31/03/2000	Average		
	30/06/2000	Average	5,994	4%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
NSW				
Throsby				
	31/03/2000	Low		
	30/06/2000	Low	4,326	4%
Warringah				
	31/03/2000	Very High		
	30/06/2000	Very High	4,929	5%
Watson				
	31/03/2000	Low		
	30/06/2000	Average	4,263	4%
Wentworth				
	31/03/2000	Very High		
	30/06/2000	Very High	5,032	5%
Werriwa				
	31/03/2000	Low		
	30/06/2000	Low	5,445	5%
NT				
Northern Territory				
	31/03/2000	Low		
	30/06/2000	Average	6,051	4%
QLD				
Blair				
	31/03/2000	Average		
	30/06/2000	Average	4,221	4%
Bowman				
	31/03/2000	Average		
	30/06/2000	Average	5,767	6%
Brisbane				
	31/03/2000	Average		
	30/06/2000	High	5,057	5%
Capricornia				
	31/03/2000	High		
	30/06/2000	High	6,169	6%
Dawson				
	31/03/2000	Average		
	30/06/2000	High	6,028	5%
Dickson				
	31/03/2000	Average		
	30/06/2000	High	5,478	5%
Fadden				
	31/03/2000	Average		
	30/06/2000	Average	6,037	6%
Fairfax				
	31/03/2000	Low		
	30/06/2000	Average	3,609	3%
Fisher				
	31/03/2000	Average		
	30/06/2000	Average	4,496	5%
Forde				
	31/03/2000	Low		
	30/06/2000	Low	4,317	4%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
QLD				
Griffith				
	31/03/2000	Average		
	30/06/2000	High	5,802	5%
Groom				
	31/03/2000	High		
	30/06/2000	Very High	5,971	6%
Herbert				
	31/03/2000	Average		
	30/06/2000	High	6,486	6%
Hinkler				
	31/03/2000	Average		
	30/06/2000	Average	4,790	5%
Kennedy				
	31/03/2000	Average		
	30/06/2000	Average	3,400	3%
Leichhardt				
	31/03/2000	Low		
	30/06/2000	Average	4,897	4%
Lilley				
	31/03/2000	Average		
	30/06/2000	High	4,518	4%
Longman				
	31/03/2000	Low		
	30/06/2000	Low	3,563	3%
Maranoa				
	31/03/2000	Average		
	30/06/2000	High	3,970	3%
Mcpherson				
	31/03/2000	Average		
	30/06/2000	High	6,603	6%
Moncrieff				
	31/03/2000	Average		
	30/06/2000	Average	6,484	5%
Moreton				
	31/03/2000	Average		
	30/06/2000	High	5,057	5%
Oxley				
	31/03/2000	Low		
	30/06/2000	Low	3,673	3%
Petrie				
	31/03/2000	Low		
	30/06/2000	Average	4,367	4%
Rankin				
	31/03/2000	Low		
	30/06/2000	Low	4,936	4%
Ryan				
	31/03/2000	Very High		
	30/06/2000	Very High	5,521	5%
Wide Bay				
	31/03/2000	Low		
	30/06/2000	Average	3,081	3%
SA				

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
SA				
Adelaide				
	31/03/2000	High		
	30/06/2000	High	2,662	3%
Barker				
	31/03/2000	Low		
	30/06/2000	Low	1,883	2%
Bonython				
	31/03/2000	Low		
	30/06/2000	Low	3,420	3%
Boothby				
	31/03/2000	Very High		
	30/06/2000	Very High	3,096	3%
Grey				
	31/03/2000	Low		
	30/06/2000	Low	1,709	2%
Hindmarsh				
	31/03/2000	High		
	30/06/2000	High	2,914	3%
Kingston				
	31/03/2000	Low		
	30/06/2000	Average	4,271	4%
Makin				
	31/03/2000	Average		
	30/06/2000	Average	4,553	4%
Mayo				
	31/03/2000	High		
	30/06/2000	High	4,097	4%
Port Adelaide				
	31/03/2000	Average		
	30/06/2000	Average	2,760	3%
Sturt				
	31/03/2000	Very High		
	30/06/2000	Very High	2,728	3%
Wakefield				
	31/03/2000	Low		
	30/06/2000	Average	2,634	2%
TAS				
Bass				
	31/03/2000	Average		
	30/06/2000	High	4,565	6%
Braddon				
	31/03/2000	Low		
	30/06/2000	Low	3,078	4%
Denison				
	31/03/2000	High		
	30/06/2000	Very High	4,467	6%
Franklin				
	31/03/2000	High		
	30/06/2000	Very High	4,891	6%
Lyons				
	31/03/2000	Average		
	30/06/2000	Average	4,287	5%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
VIC				
Aston				
	31/03/2000	High		
	30/06/2000	High	5,983	5%
Ballarat				
	31/03/2000	Average		
	30/06/2000	High	4,765	4%
Batman				
	31/03/2000	Low		
	30/06/2000	Average	3,844	3%
Bendigo				
	31/03/2000	Average		
	30/06/2000	Average	3,483	3%
Bruce				
	31/03/2000	Average		
	30/06/2000	High	4,378	4%
Burke				
	31/03/2000	Low		
	30/06/2000	Average	4,451	4%
Calwell				
	31/03/2000	Low		
	30/06/2000	Low	4,706	3%
Casey				
	31/03/2000	Average		
	30/06/2000	High	6,138	5%
Chisholm				
	31/03/2000	High		
	30/06/2000	High	4,400	4%
Corangamite				
	31/03/2000	High		
	30/06/2000	High	4,512	4%
Corio				
	31/03/2000	Average		
	30/06/2000	Average	4,370	4%
Deakin				
	31/03/2000	High		
	30/06/2000	High	4,950	5%
Dunkley				
	31/03/2000	Average		
	30/06/2000	Average	6,184	6%
Flinders				
	31/03/2000	Average		
	30/06/2000	Average	4,730	4%
Gellibrand				
	31/03/2000	Low		
	30/06/2000	Low	2,912	3%
Gippsland				
	31/03/2000	Low		
	30/06/2000	Low	2,642	2%
Goldstein				
	31/03/2000	Very High		
	30/06/2000	Very High	5,015	4%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
VIC				
Higgins				
	31/03/2000	Very High		
	30/06/2000	Very High	4,324	4%
Holt				
	31/03/2000	Low		
	30/06/2000	Low	4,885	4%
Hotham				
	31/03/2000	Average		
	30/06/2000	Average	3,797	3%
Indi				
	31/03/2000	Low		
	30/06/2000	Low	4,250	4%
Isaacs				
	31/03/2000	Low		
	30/06/2000	Average	5,029	4%
Jagajaga				
	31/03/2000	High		
	30/06/2000	High	5,603	5%
Kooyong				
	31/03/2000	Very High		
	30/06/2000	Very High	4,350	4%
La Trobe				
	31/03/2000	Average		
	30/06/2000	Average	5,875	5%
Lalor				
	31/03/2000	Low		
	30/06/2000	Low	4,318	4%
Mallee				
	31/03/2000	Low		
	30/06/2000	Average	3,966	3%
Maribyrnong				
	31/03/2000	Low		
	30/06/2000	Average	3,688	3%
Mcewen				
	31/03/2000	Average		
	30/06/2000	Average	5,092	5%
Mcmillan				
	31/03/2000	Low		
	30/06/2000	Low	2,841	3%
Melbourne				
	31/03/2000	Low		
	30/06/2000	Average	4,323	3%
Melbourne Ports				
	31/03/2000	High		
	30/06/2000	High	4,364	4%
Menzies				
	31/03/2000	Very High		
	30/06/2000	Very High	4,897	5%
Murray				
	31/03/2000	Average		
	30/06/2000	Average	3,529	3%

	Date	Level of Cover	Increase in People Covered	Increase in Est. Participation
VIC				
Scullin				
	31/03/2000	Low		
	30/06/2000	Average	4,780	4%
Wannon				
	31/03/2000	Low		
	30/06/2000	Low	2,905	3%
Wills				
	31/03/2000	Average		
	30/06/2000	Average	4,031	3%
WA				
Brand				
	31/03/2000	Low		
	30/06/2000	Low	1,911	2%
Canning				
	31/03/2000	Average		
	30/06/2000	Average	1,948	2%
Cowan				
	31/03/2000	Average		
	30/06/2000	Average	1,960	2%
Curtin				
	31/03/2000	Very High		
	30/06/2000	Very High	2,294	3%
Forrest				
	31/03/2000	Low		
	30/06/2000	Average	1,063	1%
Fremantle				
	31/03/2000	High		
	30/06/2000	High	2,436	3%
Kalgoorlie				
	31/03/2000	Low		
	30/06/2000	Average	2,430	2%
Moore				
	31/03/2000	Average		
	30/06/2000	High	2,696	3%
O'Connor				
	31/03/2000	Average		
	30/06/2000	Average	1,346	2%
Pearce				
	31/03/2000	Average		
	30/06/2000	Average	2,002	2%
Perth				
	31/03/2000	Average		
	30/06/2000	Average	2,193	3%
Stirling				
	31/03/2000	High		
	30/06/2000	High	1,948	2%
Swan				
	31/03/2000	Average		
	30/06/2000	Average	2,232	3%
Tangney				
	31/03/2000	Very High		
	30/06/2000	Very High	3,167	4%

Private health insurance registrations for hospital products – Victoria

CED Name	31/03/2000	31/07/2000	Increase 31 March to 31 July
Aston	45,800	60,700	32.5%
Ballarat	37,800	47,800	26.5%
Batman	29,100	38,700	32.8%
Bendigo	30,500	40,500	32.5%
Bruce	39,400	49,500	25.6%
Burke	30,800	43,200	40.3%
Calwell	30,900	43,400	40.4%
Casey	37,100	50,800	37.2%
Chisholm	47,900	58,300	21.6%
Corangamite	40,300	51,400	27.5%
Corio	36,700	47,900	30.4%
Deakin	45,000	57,200	27.1%
Dunkley	31,900	45,000	41.1%
Flinders	30,600	42,200	37.8%
Gellibrand	20,900	29,100	39.0%
Gippsland	16,800	25,200	49.6%
Goldstein	63,300	75,100	18.7%
Higgins	60,400	70,300	16.5%
Holt	25,800	37,700	46.4%
Hotham	33,000	42,900	29.8%
Indi	22,200	34,400	55.2%
Isaacs	29,200	42,100	44.0%
Jagajaga	50,700	63,000	24.3%
Kooyong	65,800	75,700	15.0%
La Trobe	35,400	50,600	42.8%
Lalor	23,900	35,500	48.4%
Mallee	28,100	37,100	32.0%
Maribyrnong	29,700	38,700	30.0%
Mcewen	33,800	46,800	38.4%
Mcmillan	22,100	31,500	42.2%
Melbourne	32,700	43,300	32.3%
Melbourne Ports	45,700	55,600	21.6%
Menzies	54,000	65,600	21.4%
Murray	31,500	41,900	33.1%
Scullin	31,000	42,300	36.4%
Wannon	20,800	30,100	44.8%
Wills	37,700	47,700	26.5%
Grand Total	**1,328,500**	**1,738,500**	**30.9%**

Private health insurance registrations for hospital products – Victoria

NOTE: These figures are believed to underestimate the true situation. They are estimates based on 30% rebate registration information collected by the Health Insurance Commission. The underestimation is due to delays in registration of some members by health funds, following the recent large increases in health insurance membership.

Statistical Division	Estimated increase 31 March to 31 July
Barwon	29%
Central Highlands	27%
East Gippsland	57%
Gippsland	41%
Goulburn	36%
Loddon	31%
Mallee	33%
Melbourne	30%
Ovens-Murray	61%
Western District	48%
Wimmera	31%
Grand Total	**31%**

Electorate	Estimated increase 31 March to 31 July
Aston	33%
Ballarat	27%
Batman	33%
Bendigo	32%
Bruce	26%
Burke	40%
Calwell	40%
Casey	37%
Chisholm	22%
Corangamite	28%
Corio	30%
Deakin	27%
Dunkley	41%
Flinders	38%
Gellibrand	39%
Gippsland	50%
Goldstein	19%
Higgins	17%
Holt	46%
Hotham	30%
Indi	55%
Isaacs	44%
Jagajaga	24%
Kooyong	15%
La Trobe	43%
Lalor	48%
Mallee	32%
Maribyrnong	30%
Mcewen	38%
Mcmillan	42%
Melbourne	32%
Melbourne Ports	22%
Menzies	21%
Murray	33%
Scullin	36%
Wannon	45%
Wills	27%
Grand Total	**31%**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E117**

Topic: USE OF ABS AND CENSUS INFORMATION

Hansard Page: CA 70

Senator West asked:

> **You said that you did use some ABS figures and census collection district figures in your breakdowns. Have you done any statistics analysis on census collection districts and then put them into electorates?**

Answer:

> No. The Department does convert figures from various sources to an electorate basis but does not analyse data by Census Collection District (or similarly sized area) and then group to electorates. Electorate information produced by the Department is published in electorate profiles, which are available to the general public on the Department's Internet site.
>
> Concordance files are often derived from Census Collection District total population counts. However, they are only used to convert raw data from one type of geographic area into data counts for some other type of area. One common example is a concordance that allows data on a postcode basis to be converted to a Federal Electorate basis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E063**

Topic: HEALTH INSURANCE PRODUCTS

Hansard Page: CA71

Senator West asked:

What are the results of Tony Quint and Associates research in relation to the state of knowledge amongst consumers about health insurance products?

Answer:

The Tony Quint & Associates research was conducted between 21 July 1999 and 18 August 1999 and was published on 20 October 1999. The research relating to the knowledge amongst consumers about health insurance products is attached.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Additional Estimates 2000-2001 22 November 2000

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH **Question: E064**

Topic: COMPLAINTS - PHI

Hansard Page: CA72

Senator West asked:

How many complaints has the department received since 1 July in relation to private health insurance? (n.b. answer to include ministerial correspondence, emails and telephone information service).

Answer:

Since 1 July 2000 the Department has received 499 written and emailed representations to the Minister regarding private health insurance. It is not possible to determine how many of these representations were complaints.

Since 1 July 2000 the Private Health Insurance Information Line has recorded 286 complaints from callers.

MEDIBANK PRIVATE

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

Dear Mr Humphrey

As you are aware, Medibank Private gave evidence to the Senate Legislation Community Affairs Committee on Wednesday, 22 November 2000.

Senator Chris Evans asked a series of questions of Medibank Private relating to advertising and possible breaches of the Trade Practices Act. In responding to Senator Evans I indicated that 26 October (the date on which the ACCC commenced legal proceedings) was the first time Medibank Private became aware of ACCC interest in the issue.

Later, I attempted to later clarify that the lodgement of claim was preceded by correspondence (a letter from the ACCC in Canberra dated 16 October) and a conversation with the ACCC (my meeting with Commission representatives on 25 October).

Having reviewed the transcript, I believe my response was still too narrowly focussed on the prosecution action and events immediately preceding it rather than addressing Senator Evans' interest in when Medibank Private first became aware of ACCC interest.

I attach a timeline of events, which clearly shows that these issues had been the subject of correspondence with the ACCC for some weeks prior to lodgement of the statement of claim in the Federal Court. It was in June, when this correspondence commenced, that Medibank Private became aware of ACCC concern about possible breaches of the Trade Practices Act.

Medibank Private and ACCC representatives, including myself, have been meeting at least weekly since 18 October to discuss these issues on a without prejudice basis.

I hope that this information is of assistance to Senator Evans and the Committee.

Yours sincerely

Di Jay
General Manager
Corporate Services

cc Senator S Knowles - Chairman
Senator C Evans
Commissioner S Bhojani - ACCC

Timeline of events

Date	**Action**
13 June 2000	ACCC alleges breaches in MP Package Plus campaign - ACCC in WA
26 June 2000	MP responds to complaint
20 July 2000	ACCC requests further information
8 August 2000	MP provides information
14 September 2000	ACCC raises additional issues
5 October 2000	ACCC raises Switch campaign concerns
12 October 2000	ACCC and MP meet
14 October 2000	MP responds with additional information and suggests remedial action
16 October 2000	ACCC letter to MP - Commission to consider all issues
17 October 2000	MP letter to ACCC proposing remedies
18 October 2000	Commission meeting – decision to commence legal proceedings
25 October 2000	Meeting with Commissioner Bhojani – MP advised of decision
26 October 2000	MP receives statement of claim lodged in Federal Court

Variation from the 2000-01 Budget for 2000-01 Additional Estimates due to increases in Private Health Insurance Participation Rates ($ million)

* These are temporary figures which are due for review, as such they have not been identified separately in Additional Estimates.

Year	2000-01 Budget Estimates	2000-01 Additional Estimates	Variation	2000-01 AEs Increase in MBS	Total Variation
1999-00	1,567	1,533	-34	na	na
2000-01	1,882	2,214	332	130	462
2001-02	2,021	2,358	337	185	522
2002-03	2,155	2,435	280	245	525
2003-04	2,296	2,527	231	240	471

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E047**

Topic: NATIONAL INSTITUTE OF CLINICAL STUDIES "RESEARCH GRANTS"

Written Question on Notice

Senator Evans asked:

In the Department's response to Question 295 asked by Senator Evans on the 23 May 2000 $7.2 million is listed in the year 2000-01 for research grants through the National Institute of Clinical Studies.

(a) What process will be established to allocate these grants
(b) What will be the criteria for allocating them
(c) When will the grants be available?

Answer:

The role of the National Institute of Clinical Studies is to translate research into practice.

Spending by the Institute will be undertaken in its capacity as a Commonwealth owned company limited by guarantee, involving the contracting of services but not necessarily the issue of further sub-grants.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E048**

Topic: IT SPENDING

Written Question On Notice

Senator Evans asked:

(a) What direct saving has the Department of Health and Aged Care achieved as a result of the IT outsourcing to IBM GSA?

(b) Has the Department had to top up IT spending out of other budget allocations because of the $3m per annum removed from its budget as part of the outsourcing deal?

(c) John Fahey's Press release was headed "IT Outsourcing boosts small and medium businesses". Can you explain which small and medium Australian companies have participated in the IBM GSA outsourced contract and what role have they played?

(d) What proportion of total spending has been made through Australian companies and has this reached the minimum requirement of 10%?

Answer:

(a) The level of savings is dependent upon the view taken of competitive neutrality considerations and other adjustments made by DOFA:

- At the time of contract signature on 6 December 1999, including competitive neutrality considerations and including the DOFA estimate of Health and Aged Care's contract management costs, savings to the Commonwealth were $16.75m over 5 years.
- Excluding these competitive neutrality considerations, but including the DOFA estimate of HAC's contract managements costs, direct savings to HAC were expected to be $3.51m over 5 years.
- Health's experience in the past 12 months of the contract is that contract management costs are considerably higher than the DOFA estimate. If these costs are not able to be materially reduced, there will be no direct savings to Health and Aged Care.

(b) The Department's annual budget was reduced by approximately $3m on account of potential savings to be achieved through IT outsourcing. However, since the reduction in the budget, the Department has gone through extensive re-structuring – separation of business units eg. Australian Government Health Services, Australian Hearing Services and transfer of Community Service programs to the Department of Family and Community Services. These changes have required the Department to review internal allocations to program and corporate areas including State and Territory Offices. The previous allocations have little relevance for the way new allocations were arrived at.

(c) The Department of Communication, Information Technology and the Arts (DOCITA) is responsible for evaluating and monitoring Industry Development aspects of the IT Outsourcing Initiative.

(d) The Department of Communication, Information Technology and the Arts (DOCITA) is responsible for evaluating and monitoring Industry Development aspects of the IT Outsourcing Initiative.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E049**

Topic: ABS NATIONAL HEALTH SURVEY

Written question on notice

Senator Evans asked:

(a) When will the next ABS survey be conducted?

(b) When will the results become known to the Government?

(c) How long after that will the public get to see the details?

Answer:

(a) The next ABS National Health survey will be conducted between February and December 2001.

(b) and (c) The results from the 2001 NHS will become available in September 2002. All ABS publications are embargoed until release date. Consequently both the Government and the public will have access to the results at the same time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E017**

Topic: NEW ABORTION REPORT

Written question on notice

Senator Brian Harradine asked:

(a) When is the new abortion report likely to be finished?

(b) When will the NHMRC meet to discuss the new report?

(c) Is the NHMRC or any of its committees doing any other work relating to abortion at the present time? If so, please provide details.

Answer:

(a) There is no new abortion report being prepared by NHMRC.

(b) There is no new abortion report.

(c) No other projects relating to termination of pregnancy are being undertaken at the present time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E018**

Topic: CLONING OF HUMAN BEINGS

Written Question on Notice

Senator Brian Harradine asked:

> **In answer to my question of May 2nd 2000 concerning whether the NHMRC had approved funding for any research involving human embryonic stem cells, the Department listed a project by Dr Martin F Pera of Monash University entitled "Regulation of Human Embryonic Cells". This matter was pursued with the Victorian Infertility Treatment Authority concerning the legality of that research given that harvesting ES cells from a human embryo in Victoria is prohibited under the Infertility Treatment Act. The enquiry elicited the response from Professor Louis Waller, Chairman of ITA, that the NHMRC was mistaken and that this project did not involve human embryonic stem cells.**
>
> **Could the Department please confirm whether its answer to my question was mistaken, that is whether the protocol that was approved for this project indicated that human ES cells would not be used.**

Answer:

> Dr Pera's project aims to identify factors that promote the growth of human pluripotent stem cells. The project that was approved for funding by the NHMRC uses cell lines derived from human testicular teratocarcinomas as a model of human embryonic stem cells. The cell lines were not derived from embryonic material, and as such there is no question regarding the legality of the research under Victorian legislation. The approved protocol for this project makes no mention of use of human ES cells.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question No: E019**

Topic: ORGAN RETENTION PROGRAM

Written Question on Notice

Senator Brian Harradine asked:

Has the Department or the Minister responded to a letter from NSW Health Minister Craig Knowles urging uniform national action on the retention of organs following a report that large amounts of organs and other human tissue may have been collected or retained from dead people without the knowledge of their families? ('Organs taken without authority' The Australian, 11 October 2000 Page 7). If so, please provide a copy of the response or, if no formal response has been made, indicate what the Department's view on this would be.

Answer:

On 10 October 2000 the Hon C.J. Knowles MP, New South Wales Minister for Health, wrote to the Minister for Health and Aged Care, the Hon. Dr Michael Wooldridge, concerning the retention and disposal of body parts collected at autopsy.

Whilst it is a matter for States and Territories to legislate in this area, the Minister has responded to Mr Knowles and has written to the Chair of the Australian Health Ethics Committee (AHEC), Dr Kerry Breen, requesting that AHEC give consideration to this issue.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E122**

Topic: RURAL HEALTH

Hansard page: CA80

Senator Crowley asked:

Provide terms of reference for the general workforce committee established by the Health Ministers' Advisory Council

Answer:

The Australian Health Ministers' Advisory Committee, at its 1 June 2000 meeting, agreed to establish a sub-committee, known as the Australian Health Workforce Advisory Committee (AHWAC) to:

- Undertake broader health workforce planning;
- Maintain links with the ITAB work in the Vocational Education and Training Sector through the existing CEOs group; and
- Undertake an initial focus on Nursing Sub-Specialities of Intensive Care/Critical Care, Emergency Service, Aged Care, Mental Health and Midwifery using the model of the AHWAC Reference Groups, and co-locating the Secretariat support with the existing AMWAC Secretariat.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E069**

Topic: OPTUS CONTRACT TO MODEL THE IMPLEMENTATION OF AN INTEGRATED ELECTRONIC SYSTEM AT BENDIGO HOSPITAL

Hansard Page: CA 84

Senator West asked:

(a) Who made the decision to locate this project at Bendigo Hospital? Was it the Minister and the Victorian government or was it through the Department?
(b) Justification for this project in the annual report is shown under category F, 'The government specifically requests an independent external report.' Who in the government requested that report and what was the reason it was provided?
(c) The selection process for this contract was given a category 3 – direct engagement of a recognised and pre-eminent expert. How was it determined to give such a large contract to Optus? What were the criteria that were used and why was it decided that they were a recognised and pre-eminent expert?
(d) What process was taken to determine the most suitable consultant to carry out this task and who decided that the contract should not go out to an open tender?

Answer:

(a) Optus proposed Bendigo as the test site for the E-health project. The agreement of the Victorian government and the relevant Victorian regional hospital was sought and obtained.

(b) The project was initially proposed by Optus as a co-operative arrangement involving participation and input from a range of stakeholders including local and State Governments, a selected regional hospital, health workers and health service recipients.

(c) Optus approached the Minister's Office and the Department with a proposal. It was considered worthy of funding because it addressed the lack of models in the Australian health care sector to describe overall communications requirements, and was therefore a substantial investment of intellectual property.

(d) See answer to Question (C) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E071**

Topic: BENDIGO HOSPITAL

Hansard Page: CA 85

Senator West asked:

(a) What tangible benefits have been delivered to the Bendigo Hospital as a consequence of that project?

(b) Has this project been subject to an independent assessment to determine whether the outcomes met the requirements established at the start of the project and have the finances of the project been subject to an independent audit?

Answer:

(a) $120,000 was made available to the Bendigo Health Care Group by Optus to offset the cost of participation in the project by hospital personnel.

(b) The report has been reviewed internally. The finances of the project have not as yet been subject to an independent audit.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E070**

Topic: HORIZON PROJECT

Hansard Page: CA 85

Senator West asked:

(a) You might like to advise me on notice of who is involved totally with that project and how they were each decided upon, whether it was an open tender and the criteria used for the selections. I am interested to know whether Mr Maine was the originator of the proposal and whether he was the author of the proposal that the Department assessed.

(b) I want to know what involvement the Minister's Office had in the development of this proposal and of them being let.

(c) Is the Department aware of a success fee allegedly paid to Mr Maine by Optus for his role in them being awarded this contract?

(d) What is the Department's position on the awarding of success fees for the award of contracts from the Department which have not gone to tender?

(e) Has the Department investigated allegations of a business or employment relationship between the principal parties of this contract and Ms Barbara Hayes after she left the office of the Minister?

(f) At what stage did the involvement of Mr Tony Maine in this project cease and who took over his role?

Answer:

(a) The National Farmers' Federation came forward with a proposal to pool the financial and intellectual resources of a number of key players so that the problem of access by people living in rural and remote Australia to communication and information services could be addressed in a coherent and strategic way. A contract was established with the National Farmers' Federation on behalf of the Horizon Project Group. The Horizon Project Group included personnel from the National Farmers' Federation, Ernst & Young Consulting, Optus Communications and Maine Marketing.

(b) The Horizon Project was proposed to the Minister by the National Farmers' Federation (NFF), emerging from a NFF discussion paper entitled *Trends in the Delivery of Rural Health, Education and Banking Services* (Feb 1997). The proposal was thought likely to be able to respond to an urgent need for scoping e-health activities in rural and remote Australia as indicated by the report of the Australian National Audit Office called *Planning for Rural Health* (May 1998) and in the principles underpinning the national and remote health strategy. The Minister indicated to the NFF his interest in establishing such a strategic study and provided his support to the project. A press release was issued to this effect on 28 August 1998 jointly with the then Deputy Prime Minister. The Department entered into a contract with the National Farmers' Federation for the Horizon project in October 1998.

(c) No.

(d) The Department's policy is to follow the Commonwealth Procurement Guidelines and the Chief Executive Instructions.

(e) The Department is not aware of any such allegations.

(f) The Department does not have such information.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E072**

Topic: BENDIGO HOSPITAL & HORIZON PROJECT

Hansard Page: CA 85

Senator West asked:

Was there no consultation or proposals from Telstra put in for either the Bendigo Hospital or Horizon Projects? It was all done with Optus?

Answer:

Telstra had not evinced any interest in or demonstrated expertise in this area of health information technology/communications, and was therefore not approached to work up a competing proposal.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimate 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: 120**

Topic: NATIONAL INSTITUTE OF CLINICAL STUDIES

Hansard Page: CA 74

Senator West asked:

What is the remuneration for people appointed to the Board. I am interested in knowing how that is determined.

Answer:

Suggested rates of remuneration for the NICS Board of Directors were determined in consultation with the Remuneration Tribunal (the Tribunal).

The Department sought an interim Determination of remuneration for the Directors of the Institute (in advance of registration of the company), from the Tribunal which on 19 September 2000, recommended the following rates:

- an annual fee for the Chair of $51,600 and $9,200 for other Directors; and
- Tier 1 travelling allowances for the Chair and Tier 2 travelling allowances for other Directors.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: 150**

Topic: NATIONAL INSTITUTE OF CLINICAL STUDIES

Hansard Page: CA 74

Senator West asked:

Did the Department have a role in drawing up the Minister's press release (announcing the appointment of the National Institute of Clinical Studies Board of Directors)?

Answer:

Yes. The Department provided an initial draft press release to the Minister's office for consideration, as is normal practice.

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Constitution FINAL.DOC

Constitution of National Institute of Clinical Studies Limited

Corporations Law of the Australian Capital Territory

1.

TABLED 22.11.00

TABLE OF CONTENTS

Constitution of National Institute of Clinical Studies Limited

Corporations Law of the Australian Capital Territory

The Commonwealth consents to be the member of National Institute of Clinical Studies Limited and agrees that:

1. CONSTITUTION

1.1. This document, as amended from time to time in accordance with the Law, will be the Constitution of National Institute of Clinical Studies Limited, a public company limited by guarantee.

2. REPLACEABLE RULES

2.1 Subject to clause 2.2, the Replaceable Rules set out in the Corporations Law apply to the company to the extent that they apply to companies limited by guarantee and are not inconsistent with this Constitution.

2.2 The Replaceable Rules set out in sections 201G (company may appoint a Director), 201H (Directors may appoint other Directors), 203A (Director may resign by giving written notice to company), 198C, 201J and 203F (Managing Director), Section 248E (Chairing Directors meetings), [Section 202A (Remuneration of Directors)] and Section 248F (Quorum of Directors meetings) of the Law do not apply to this Company.

3. COMPANY'S OBJECTS AND POWERS

3.1 The Company's objects are to:

(a) lead the continuous improvement of clinical practice and its delivery;

(b) engage stakeholders including practitioners, consumers, funders, managers and researchers in the improvement of clinical services; and

(c) foster, inform and evaluate the implementation of best practice clinical standards, with careful attention to incentives and obstacles.

3.2 The Company has the powers set out in the Law but only to do all things that are necessary, convenient or incidental to carry out the objects set out in clause 3.1.

3.3 Without limiting clause 3.2 above, the company has power to, in the course of pursuing its objects:

(a) map current activity around improving quality and clinical care, and provide a focus for the consolidation and dissemination of that work;

(b) support research to assess and evaluate aspects of the system within which care is provided – including the processes, interactions and relationships – to identify mechanisms to improve care delivery and the most effective means to influence their implementation;

(c) identify the best mechanisms to influence and improve clinical practice, in concert with the profession;

(d) establish working groups and advisory structures to report and advise on a wide range of matters relating to clinical improvement in the Australian Health system;

(e) champion best practice within the health care system through education and training;

(f) build links between professionals, consumers and other key stakeholders to improve exchange of information and experience about the operation of the health care system and minimise duplication of effort;

(g) in collaboration with the relevant agencies and bodies promote the collection and analysis of data and the development of effective data systems; and

(h) build links both nationally and internationally with organisations with similar objectives and identify and assess relevant overseas approaches for clinical practice improvement.

4. APPLICATION OF COMPANY'S PROPERTY

4.1 Subject to this clause and subclause 17.3, all the Company's income and property must be applied solely towards the promotion of the Company's objects contained in clause 3 and must not be paid or transferred, directly or indirectly, by way of dividend, bonus or otherwise to the members.

4.2 Subclause 4.1 does not prevent the payment of reasonable and proper remuneration of an officer of the Company or a member in return for goods or services supplied to the Company by that officer or member,or the repayment of any monies to the Commonwealth under the terms of any relevant funding agreement.

5. IDENTIFICATION OF MEMBERS

5.1 The members of the Company are the subscribers to this Constitution.

6. COMPANY MUST BE WOUND UP IF COMMONWEALTH WISHES TO CEASE TO BE A MEMBER

6.1 The Commonwealth may, by written notice to the Company, give notice of its intention to withdraw from its membership in the company. Upon receipt of a notice of intention to withdraw, the Company must commence to wind up the company by resolving to wind up the Company voluntarily under s.491 of the Corporations Law.

7. APPOINTMENT OF DIRECTORS

7.1 There shall be a minimum of 3 and a maximum of 9 Directors.

7.2 The first Directors of the Company are the persons named in the following table:

Name	Term
Professor Chris Silagy, AO	3 years
Professor Geoffrey H. Tofler	3 years
Dr Jill Sewell	3 years
Dr Chris Baggoley	3 years
Professor David Fetcher	3 years
Dr Bruce Chater	3 years
Dr Karda Cavanagh	3 years
Dr Rachel David	3 years
Ms Genevieve Cantwell	3 years

7.3. Subject to this Clause, the Minister may at any time appoint a person to be a Director of the Company by notice in writing to the Company, [subject to Clause 7.1] for such period and on such terms and conditions, including as to remuneration, as the Minister thinks fit.

7.4 Subject to this clause, the Minister may at any time remove a Director by sending notices in writing advising of the removal and the date of its effect, to both the Company and the Director.

7.5 A Director may resign his office by sending two-week's notices in writing, advising of the resignation and date of its effect, to the Minister and the Secretary of the Department of Health and Aged Care.

7.6 The Minister may vary an appointment under this clause by notice in writing.

7.7 The Minister may, by written notice upon application by a Director, give that Director leave of absence from acting as a Director or from attending Board meetings, for such period or number of meetings as is specified in the notice.

8. PERIOD OF OFFICE OF DIRECTORS

8.1 Subject to the Law, (section 203D - removal by the members) and clauses 7.4, 7.5, 7.6 and 9 of this Constitution, the first Directors hold office for the period set out opposite their names in the table in clause 7.2. Otherwise (subject to those provisions) a Director is appointed for the term determined by the Minister.

8.2 A Director retires on the expiration of his or her term of office but is eligible for re-appointment.

9. VACATION OF OFFICE OF DIRECTORS

9.1 In addition to the situations set out in the Law, the office of a Director will become vacant if the Director:

(a) is absent without the consent of the Minister given under clause 7.7 from:

(i) meetings of the Directors held during a period of 6 months; or

(ii) 4 consecutive meetings; or

(b) is directly or indirectly interested in any contract or proposed contract with the Company and fails to:

(i) declare the nature of that interest to the other Directors as soon as practicable after the relevant facts have come to the Director's notice; and

(ii) comply with any resolution of the other Directors on the matter.

9.2 In subclause 1 above, a reference to a contract or proposed contract with the Company includes but is not limited to a grant of financial assistance or proposed grant of financial assistance by the Company.

10. REMUNERATION OF DIRECTORS

10.1 The Directors of the Company, including the Chair and the Deputy Chair, are to be paid such remuneration as the Minister determines.

10.2 The Minister must consult the Remuneration Tribunal on the remuneration of the Directors.

11. CHAIRING DIRECTORS' MEETINGS

11.1 The Minister must appoint a Director to chair Directors' meetings. The Minister may determine the period for which the Director is to be the Chair.

11.2 The Minister may appoint a Deputy-Chair to perform the duties of Chair in the place of the Chair if an appointed Chair is not available or declines to perform the duties.

11.3 If the Minister has not appointed a Deputy Chair to perform the duties of Chair in the place of the Chair, and the Chair is not available or declines to perform the duties, the Directors may appoint one of them to perform the duties as Chair in the absence of the Chair and the Deputy Chair.

11.4 An appointed Chair or Deputy Chair may resign from the position of Chair or Deputy Chair, but remain as a Director, by giving two-week's notice in writing to the Minister and the Company.

11.5 The Minister may revoke or vary an appointment under this clause by notice in writing.

11.6 A Chair or Deputy Chair who ceases to be a Director automatically vacates his or her office as Chair or Deputy Chair.

12. QUORUM AT A DIRECTORS' MEETING

12.1 The quorum for a Directors' meeting is a majority of Directors holding office at the time of the meeting and the quorum must be present at all times during the meeting.

13 CHIEF EXECUTIVE OFFICER

13.1 The Directors of the Company, after consultation with the Minister, may appoint a person (other than a director appointed under clause 7) to the office of Chief Executive Officer of the Company. The terms of the appointment (including as to remuneration) must be agreed by the Minister.

13.2 The person appointed as Chief Executive Officer under clause 13.1 will not be a Director of the company.

13.3 The Directors may confer on a Chief Executive Officer any of the powers that the directors can exercise.

13.4 The Directors may revoke or vary:

(a) an appointment; or

(b) any of the powers conferred on the Chief Executive Officer.

13.5 Subject to the Law, any compensation payable to a person in respect of the revocation of that person's appointment as Chief Executive Officer will be governed by the terms of any agreement between the company and that person.

13.6 The Directors may invite the Chief Executive Officer to attend Board meetings, but he or she will have no right to attend those meetings or to vote at those meetings and will not be counted in the quorum for those meetings.

14. MINISTER MAY GIVE NOTICE TO COMPANY AS TO PERSONS WHO MAY EXERCISE COMMONWEALTH AND MINISTERIAL POWERS UNDER THIS CONSTITUTION

14.1 The Minister may give a notice in writing to the company that the Commonwealth's interests as a member of the company and the Minister's powers under this Constitution may be exercised by a person named in the notice, or as directed by that person in writing.

14.2 A notice is effective if it is in writing, signed by the Minister and a copy has been forwarded to the Secretary of the Company. If the Company receives a notice under this clause, the company may rely on the person named in the notice or as directed by that person, to exercise the powers of the Commonwealth, and the Minister's powers, in respect of the company.

14.3 The Minister may revoke or vary a notice under this clause at any time in writing.

15. INDEMNITY AND INSURANCE

15.1 To the extent permitted by the Law, the Company indemnifies every person who is or has been a Director, Secretary, or executive officer of the Company, and may indemnify every person who is or has been an auditor of the Company, against

(a) any liability incurred by that person in his or her capacity as a Director, Secretary, auditor or executive officer of the Company other than:

(i) a liability owed to the Company or a related body corporate, or

(ii) a liability for a pecuniary peralty order under section 1317G or a compensation order under section 1317H, or

(iii) a liability that is owed to someone other than the Company or a related body corporate which did not arise out of conduct in good faith; and

(b) any liability for legal costs incurred by that person in his or her capacity as a Director, Secretary, auditor or executive officer of the Company other than:

(i) in defending or resisting proceedings in which the person is found to have a liability for which they could not be indemnified under clause 15.1(a); or

(ii) in defending or resisting criminal proceedings in which the person is found guilty; or

(iii) in defending or resisting proceedings brought by ASIC or a liquidator for a court order if the grounds for making the order are found by the court to have been established (except in relation to costs incurred in responding to actions taken by ASIC or a liquidator as part of an investigation before commencing proceedings for a court order); or

(iv) in connection with proceedings for relief to the person under the Law in which the Court denies the relief.

15.2 The Company may, where the Directors consider it appropriate to do so, pay or agree to pay a premium in respect of a contract insuring a person who is or has been a Director, Secretary, auditor or executive officer of the Company, against:

(a) any liability incurred by that person in his or her capacity as a Director, Secretary, auditor or executive officer of the Company other than a liability which arises out of:

(i) conduct involving a wilful breach of duty in relation to the Company; or

(ii) a contravention of section 182 (Use of Position) or section 183 (Use of Information) of the Law; and

(b) any liability for legal costs incurred by that person in his or her capacity as a Director, Secretary, auditor or executive officer of the Company in defending proceedings, whether civil or criminal, whatever their outcome, and without the qualifications set out above.

16. WINDING UP

16.1 Each member undertakes to contribute not more than $10 to the property of the Company if the Company is wound up.

17. SURPLUS ASSETS

17.1 If upon the winding up or dissolution of the Company there remains, after satisfaction of all its debts and liabilities, any property, this property must only be given or transferred to an organisation or organisations with:

(a) similar objects to the objects of the Company (as contained in clause 3); and

(b) a constitution which prohibits the distribution of its income and property at least to the extent set out in clause 4.

17.2 The identity of the transferee referred to in subclause 17.1 will be determined by the members by ordinary resolution at or before the time of the winding up or dissolution of the Company.

17.3 If a transferee under clause 17.1 cannot be found, surplus assets must be transferred to the Commonwealth.

18. DEFINITIONS

18.1 In this Constitution, unless the contrary intention appears:

- 'Chair' means the Chair appointed under clause 11;
- 'Company' means National Institute of Clinical Studies Limited;
- 'Constitution' means this document as amended from time to time;
- 'Director' means any person occupying the position of Director of the Company and includes an Alternate Director;
- 'Directors' means all or some of the Directors acting as a board;
- 'Law' means the Corporations Law in force throughout Australia as set out in section 82 of the *Corporations Act 1989*;
- 'member' means a person described as a member of the Company in clause 5 and includes a member present by proxy;
- 'Minister' means either:
  - (a) the responsible Minister for the Company from time to time under the *Commonwealth Authorities and Companies Act 1997*; or
  - (b) if an arrangement exists between the responsible Minister and a junior assisting Minister whereby the responsibility for oversight of the Company has been passed to the junior assisting Minister, the junior assisting Minister;
- 'Remuneration Tribunal' means the Remuneration Tribunal established by the *Remuneration Tribunal Act 1973*;
- 'Replaceable Rules' means the provisions referred to in section 141 of the Law;
- 'Secretary' means a person appointed by the Directors to perform any of the duties of secretary of the Company.

18.2 In this Constitution unless the contrary intention appears:

- words importing the singular include the plural and vice versa;
- words importing any gender include the other genders;

- words or expressions defined in the Law have the same meaning;
- headings do not affect construction or interpretation;
- a reference to a person includes a body corporate and a body politic, and
- an expression in a clause that deals with a matter dealt with by a particular provision of the Law has the same meaning as in that provision of the Law.

19. SIGNING

19.1. Signed by the Commonwealth of Australia, acting through the [Responsible] Minister, [the Hon. Dr Michael Woodridge M.P.]

.....

[ ]

/ /2000

Witnessed by [ ]:

.....

Witness

/ /2000

NB: While the Commonwealth is the sole member of this company, the company is subject is the operation of the *Commonwealth Authorities and Companies Act 1997* and must comply with reporting provisions contained in that Act.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E121**

Topic: DOCTORS IN RURAL AREAS PRACTISING UNDER OVERSEAS TRAINED DOCTORS EXEMPTION SCHEMES

Hansard Page: CA78

Senator WEST asked:

(a) How many doctors in rural areas are practising out there under an exemption scheme related to the overseas trained doctors in Australia as temporary residents? Do we know that?

(b) I am interested to know what that figures have done over a period of time. How many are out there also under schemes for overseas trained doctors have been given permanent Australian residency?

Answer:

(a) The table below shows the estimated number of exemptions granted under section 3J of the *Health Insurance Act 1973* (the Act) to allow temporary resident doctors to provide professional services that attract a benefit under the Medicare Benefit Schedule, in rural areas classified as RRMA 3-7.

Financial year	Exemption numbers for RRMA 3-7 locations	Doctor numbers (headcount)
1999/00	2081	685

Notes:

1) The number of exemptions is greater than the number of doctors, reflecting the fact that many of the doctors worked in more than one rural location and some doctors renewed short-term locum exemptions throughout the year.

2) It should be noted that an additional number of temporary resident doctors work in State and Territory public hospitals and have access to a "class exemption" under section 3J of the Act to refer and prescribe only.

In the 1998/99 financial year, 939 exemptions were granted for rural areas classified RRMA 3-7 under section 3J of the Act.

(b) Under the new State and Territory overseas trained doctor recruitment schemes there are currently 79 overseas trained doctors practising in Queensland, Western Australia and Victoria. The scheme is currently being implemented in the other states and the Northern Territory. So far sixteen doctors working on these schemes have been awarded permanent residency or citizenship.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Supplementary Budget Estimates 2000-2001 22 November 2000

OUTCOME 9: HEALTH INVESTMENT **Question: E059**

Topic: QUALITY PLANS

Hansard Page: CA 23

Senator Evans asked:

> **Perhaps you could take on notice which ones (quality plans) you have and when you received them**

Answer:

> This information was provided at 22 November 2000 Senate Estimate Hearings. Please refer to the Hansard (CA 91).

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SENATE ESTIMATES QUESTIONS

TIMING OF PROVISION OF ANSWERS

TO THE COMMITTEE SECRETARIAT

	02-May	22-23 May	Total	Cum Total
May	77	-	77	77
June	54	-	54	131
July	11	-	11	142
August	9	-	9	151
September	14	225	239	390
October	17	49	66	456
November	2	23	25	481
	184	297	481	

2 May Hearings - 184 questions were taken on notice

22-23 May Hearings -294 questions were taken on notice
3 questions were answered in 2 parts
297 answers were sent to the Committee

TABLED AT HEARING 22.11.00

SENATE STANDING COMMITTEE ON COMMUNITY AFFAIRS

DEPARTMENT OF HEALTH AND AGED CARE

On 22 November 2000, SENATOR CROWLEY asked:

Does the Department have a policy or set procedures for email correspondence?

- Yes (see Attachment A).

- All email correspondence has the same status as correspondence received in hard copy. Emails initially receive attention from either the Department's Webmaster, an officer of the Department, or staff of the ministerial offces depending on which website receives the email.

- Under the Electronic Transactions Act (ETA) effective 1 July 2001, the Department, in most cases, will be required to accept electronic transactions but can specify the format of those transactions.

- A significant amount of email is currently received and handled by Departmental offcers. To more effectively and efficiently handle email under the ETA, electronic mail boxes will be set up that will ensure that email correspondence is directed to the right area, and that it is handled promptly and appropriately.

- The implementation of the ETA will require the Department to acquire appropriate public key infrastructure (PKI)
  - PKI involves encryption and digital signatures to ensure identification and nonrepudiation of those dealing with the Department electronically.

What is the process for handling constituents corresponding with **the Minister via email?**

- Email is received by the relevant ministerial website.
- Email is viewed and marked for appropriate action by appropriate staff within the ministerial office.
- Emails requiring a response are forwarded to the Department's parliamentary area for processing and allocating to an action area where a response is then prepared.
- Within the Department, normal ministerial correspondence procedures are followed for the processing, preparation and clearance of email correspondence.
- Final responses are then electronically forwarded back to the Minister's Ofce staff for matching with the original email and electronic reply to the correspondent from the ministerial website.

What numbers of ministerial emails are received?

The Department has only had the capacity to identify and report on emails received by the ministerial offices since the introduction of the MIRACLS 2 tracking system in May 1999. MIRACLS 2 records show the Department actioned, on behalf of the ministerial offices, 237 emails in 1999 and 31 5 emails to date in 2000.

Is the response in hardcopy or electronic?

It is generally the case that emails are responded to electronically unless the correspondent has requested a hard copy response to a physical location which they have provided, or it is determined that information to be included in the response is not available electronically. In the later instance a hard copy package is prepared containing relevant attachments and/or enclosures.

Responses to email correspondents.

The Department exercises the same judgement in accepting the authenticity of email correspondence as it does with written correspondence. In responding to any form of correspondence the Department provides any relevant, available and appropriate information in order to address the issues raised by the correspondent in context of the Department's relationship with that correspondent eg members of the public, State Departments, service providers etc..

Commonwealth Department of Health and Aged Care [Attachment A]

Minute

First Assistant Secretaries
Assistant Secretaries
Divisional Liaison Officers
cc. Executive

DEPARTMENTAL POLICY ON EMAIL CORRESPONDENCE

A number of questions have been raised about how incoming email correspondence should be handled within the Department. The purpose of this Minute is to provide some general advice on issues that departmental staff should be mindful of in relation to incoming email correspondence.

There are three ways email correspondence might be received in the Department. An email might be directed to an individual, it may be addressed to one of the many websites hosted by the Department, or it may be forwarded on from one of the portfolio's parliamentary offices. Regardless of the avenue through which it is received, the email will fall into one of two categories - departmental correspondence or ministerial correspondence.

All email correspondence has the same status as correspondence received in hard copy through more traditional channels and should be treated accordingly. There are also legal and other requirements stemming from the *Electronic Transactions Act* 1999, the government on line strategy and the Commonwealth Principles of Responsible Records Management which dictate the manner in which we manage email correspondence.

Electronic Transactions Act 1999
This Minute is not intended to provide details of the implications of the *Electronic Transactions* Act 1999 for your Division. You will by now have received a ?Minute from Stephanie Gunn, Assistant Secretary, Corporate Development, dated August 2000, regarding the legislation which has been included in the *Electronic Transactions Regulations* 2000 and to which the *Electronic Transactions* Act 1999 applies as from 1 July 2000. If you have further queries regarding the Act, please do not hesitate to contact Dianne Garner on x5029.

Emailed ministerial correspondence
Procedures have been developed and implemented for the management of emailed ministerial correspondence received in the Department via the parliamentary offices. These procedures lave worked effectively to date but may be revisited if the volume of email correspondence received increases substantially. The Ministers' offices will determine if a response is required. If so, the procedures detailed at Attachment A should be followed.

It is also possible that an item of ministerial correspondence will be received at one of the Department's websites. For example, it is conceivable that a letter to Dr Wooldridge could be sent to the Mental Health and Wellbeing website.

If this happens, it is important for the action area to forward that item of email correspondence to their respective ministerial contact officer in PAPA Branch to ensure it is tracked and responded to in accordance with the procedures at Attachment A.

Emailed departmental correspondence
It is up to each program area to ensure that appropriate procedures are in place for handling all correspondence they receive in a responsible and accountable manner. This applies to email correspondence as well as any other correspondence addressed to the Department.

The Public Affairs Unit monitors the Departmental website for emails received via the Department's Webmaster Account. The Account is checked at least twice a day and any correspondence forwarded to identified contact people in the relevant program area. The current list of contacts is at Attachment B. Please advise Madeleine Kaye (02) 6289 1264 if any updates are required to ensure correspondence is forwarded appropriately.

There is also a number of other sites hosted by the Department and it is essential that any area responsible for a website has in place a similar procedure to ensure any incoming correspondence is forwarded to an appropriate action area quickly.

Procedures for actioning email correspondence appropriately would take account of (but not be limited to) the following:

- Conscious decisions must be made about which area of the Division is responsible and who will respond.
- Action officers should follow established divisional or branch procedures for clearance of responses (including decisions on whether a response is necessary).
- Good record keeping is critical to the Department's integrity. The Department must comply with various legislative requirements to meet accountability and regulatory requirements. Action officers are responsible for ensuring that they undertake responsible records management in accordance with the Principles of Responsible Records Management. These principles are available on the Records Management Centre Intranet Site: http://intranet.csd/fmb/rmc/coverrmc.htm
- The Electronic Transactions Working Group (now GoNet) has recommended that each branch establishes a branch address for correspondence and that this address be publicised. This would help avoid emails being addressed to a particular person within the Branch that can sometimes be overlooked (eg officer may be on leave).
- The Working Group also recommended that each Branch develop a set of procedures for handling electronic responses.
- Internet users and people who use email often anticipate a fast turnaround to their queries. Where timely responses are not possible, acknowledgment of receipt of the email should be considered.

Please contact Shirley Browne on (02) 6289 5156 if you have any queries regarding this matter.

AUTHORISED FOR ELECTRONIC TRANSMISSION BY
JAN FENELEY
Assistant Secretary
Public Affairs, Parliamentary and Access Branch
7 September 2000

ATTACHMENT A

EMAIL CORRESPONDENCE

MINISTERS' WEBSITE

Emails to Ministers' home pages

Emails that can be handled without departmental input may be answered by the appropriate person in the relevant Minister's Office.

Where the Minister's Office decides that departmental input is required, the email will be sent to the Department for attention as a ministerial M response, and handled by action areas in the same way as paper correspondence.

All responses to mail received on Ministers' websites must be sent from that website - that is, direct from the Minister's office. Program areas **must not** email responses direct to electronic correspondents contacting Ministers' sites. The emails pass through the following steps.

Stage	Description
1	Minister's Office forwards email to the Ministerial Correspondence Unit in Parliament Section
2	Parliamentary Section prints item, allocates it, records it as an item of ministerial correspondence on MIRACLS2 and forwards it to the action area in a corres ondence folder as with other correspondence
3	Response is prepared and cleared by action area and then emailed to MINCORRO mail-in database, with hard copy forwarded in the folder to the relevant Ministerial Officer in Parliament Section
4	Parliamentary Section clears the response, electronically matches it with the incoming email, forwards both by email to the Minister's office for clearance, and updates MIRACLS2
5	Minister's office clears response, and forwards both the response and the original email to the electorate office
6	Minister's electorate office emails the response to the original author and advises Ministerial Officer that the response has been provided
7	Ministerial Officer prints the final electronic response, updates the MIRACLS2 record, and returns the hard copies of the original email and the response to the action area for filing

Commonwealth Department of Health and Aged Care

Minute

All Staff

REVISED CHIEF EXECUTIVE INSTRUCTIONS ON INFORMATION MANAGEMENT AND RECORD KEEPING

The purpose of this Minute is to advise that I have issued a new Chief Executive Instruction (CEI) and accompanying Procedural Rules on Information Management and Record Keeping. These documents replace the existing Chief Executive Instruction 9.2 on managing electronic documents. A hardcopy of the revised CEI and Procedural Rules will be provided to all staff by mail drop. The CEI and Procedural Rules are also available on the Intranet at httl2://intranet/csd/Fmb/rules/CEls/cei9-2.htm

Good information management and record keeping is critical to the Department's capacity to achieve its objectives and deliver its outcomes. As employees of the Department we are accountable for maintaining a record of our actions and decisions taken in the course of carrying out our duties. Effective record keeping is fundamental in meeting this requirement. Good information management, particularly sharing information, is also essential for us to take advantage of the range of skills and knowledge available in the Department.

The CEI defines the obligations of all staff in managing information and record keeping. It is a comprehensive instruction that covers issues such as when to keep a record, how it is to be stored, how it should be made available for shared access and how particular types of records should be classified and secured. The CEI and Procedural Rules provide guidance in how to deal with records in paper and electronic form, including email and data on Departmental IT systems.

I ask that you take the time to familiarise yourself with your obligations under this Chief Executive Instruction and seek advice and support if necessary in ensuring that you comply with these obligations. I will also be writing to you soon about a comprehensive information management improvement program, focusing on support at a workgroup level, which is about to commence in the Department. It is important that you take advantage of this program to increase your knowledge and improve your skills in managing information.

If you have any queries about your obligations under the new Chief Executive Instruction or about the information management workgroup support program please contact the workgroup support team on 02 6289 5037.

Andrew Podger
23 October 2000

Section 9.2: Information Management and Record Keeping

Chief Executive Instructions

General

9.2.1 All paper and electronic information, documents and data gathered, created or retained by staff in the performance of their duties is the property of the Department and must be managed according to the following Chief Executive instructions.

Creating Records

9.2.2 Staff are responsible for documenting relevant or significant actions, events and conversations that occur in the performance of their duties particularly where they provide evidence of formal advice or instructions, or significant decisions, discussions or comments. This documentation must be stored and managed as part of the corporate record.

9.2.3 Staff are responsible for retaining relevant or significant documents which provide evidence of their work activities including their business decisions, consultations, communications and transactions and for ensuring that they are stored and managed as part of the corporate record.

9.2.4 E-mail is a form of business correspondence and is therefore corporate information. Where it contains formal advice or instructions, or documents significant decisions, discussions or comments it must be stored and managed as part of the corporate record.

9.2.5 To ensure that the corporate record is complete, accurate, relevant and has evidentiary value, staff should retain and file a continuum of significant documentation and information which is structured to provide evidence of the sequence and process of activities, actions or decisions as well as final outcomes.

Storing and Managing Information and Records

9.2.6 The primary responsibility for ensuring that corporate information, documents and data is stored appropriately in corporate management systems lies with the staff member who created, sent or collected it. Where this information is related to other information, documents and data in the Department it should be referenced or included in the related corporate record.

9.2.7 Corporate information, documents and data that are part of the corporate record must be stored and managed within a corporate repository. Paper documents must be attached to a Records Management paper file. Publications, audio, video and physical material which cannot be placed on a Records Management paper file must be lodged in the Department's Library and referenced on the paper file. Electronic documents or data must be stored and managed electronically within the departmental document management system or other recognised departmental management systems including personnel systems and Program IT systems.

9.2.8 All departmental IT systems which contain corporate information, documents or data including Lotus Notes databases must be registered in the departmental National Applications Register with details about the nature, use and privacy requirements of the information.

9.2.9 All corporate information, documents and data, whether paper or electronic, must have associated metadata which uniquely identifies, characterises and classifies it. This should include at a minimum the author, originator or source, the currency and lifespan of the content, the format, the context and use of the information and its relationship to other information through the use of departmental keywords.

Sharing and Access to Information and Records

9.2.10 All corporate information, document and data, whether paper or electronic, should be retrievable and accessible to those staff who are entitled to have access to it and who may contribute to its use.

9.2.11 Staff should balance the need and value of information sharing with classification and security provisions when determining access to their information.

9.2.12 When moving within or leaving the Department staff must audit and review the information they have created in the performance of their duties to ensure that it is titled, ordered and filed correctly and remains accessible to the section or team that continues to manage the relevant functions.

Legislative Requirements .

9.2.13 All records, whether paper or electronic, must be managed in accordance with the *Archives Act 1983* and are subject to related legislation such as the *Privacy Act 1988, the Evidence Act 1995, Freedom of Information Act 1982* and the *Electronic Transactions Act 1999.*

9.2.14 Staff are required to observe departmental requirements for the management and handling of classified information. This includes the assignment of appropriate levels of security to each file, record or document (whether physical or electronic). Requirements for the classification of files are contained in the Departmental Security Manual and the Commonwealth Protective Security Manual issued by Attorney General's Department.

9.2.15 Staff must not alter, destroy or dispose of Commonwealth records without authorisation.

References.
Archives Act 1983
Evidence Act 1995
Freedom of Information Act 1982
Privacy Act 1988
Electronic Transactions Act 1999
Commonwealth Protective Security Manual
Departmental Security Manual
IT & T Security Policy

Related Instructions

Section 1.8 - Ensuring the Integrity of Computer Systems Section 1.9 - Information Technology and Telecommunications Security; Section 6.12 - Accounts and Records

Procedural Rules
Procedural Rule 9.2 is maintained by the First Assistant Secretary, Corporate Services Division and explains in more detail the day-to-day responsibilities of staff in managing paper and electronic information and records.

Approved
Andrew Podger
Secretary'

23 October 2000

Section 9.2: Information Management and Record Keeping

Procedural Rules
Creating and Using Files

1. Staff are responsible for the creation of Records Management electronic and paper files and for ensuring that the file title accurately reflects the file contents. When requesting a file staff must use the free text component of the file title to identify the subject and details of the contents of the file. They must provide a minimum of 1 related document to the Records Management Centre to allow them to determine the Function, Activity and Transaction terms.

2. Staff may request either a paper or electronic Records Management file for storing their records. Electronic files should be requested where it is intended that all information on that file is stored and managed electronically in the departmental document management system. Alternatively staff can request a paper file in which case they can store paper documents on the physical file as well as electronic documents in the departmental document management system.

3. When a Records Management paper file is requested it is marked out to the requesting officer, who is then responsible for the subsequent management, local storage and security of this file. Where the person requesting the file is not the person who will manage and maintain the file, this should be identified in the request and additional details provided.

4. Workgroup files should not be used for storing corporate information, as they are only appropriate for short term or interim storage of documents.

5. The DMS Section Temporary File Number which is the electronic equivalent of a workgroup file should not be used for storing corporate information, as it is only appropriate for short term or interim storage of documents.

6. Documents that are put on file should include the author, date and version number if appropriate and should be sorted sequentially to reflect the order and process of activities, actions or decisions as well as final outcomes.

Managing Paper and Electronic Documents

7. All documents created or updated electronically that are part of the corporate record must include reference to the author, originator or source, the currency of the content, the version number and the Records Management file number in the body of the document. Where these documents are also stored electronically they must include reference to the location of the document.

8. All electronic documents must be titled according to departmental conventions. The title should be meaningful, should accurately reflect the contents of the document and provide context for the document's use or status. The language and terminology used in titling should be consistent with the Department's thesaurus.

9. All staff who create or update electronic documents in the departmental document management system must ensure that the document profile provides the necessary information to uniquely identify it and facilitate appropriate access and retrieval.

10. Final signed or electronic documents must either be identified and stored appropriately on a Records Management paper file or saved as final and stored appropriately in the departmental document management system to protect them from tampering, unauthorised alteration and from accidental or intended damage or destruction.

Managing Electronic Correspondence

11. Staff are responsible for managing their e-mail and their individual mail databases in which it is stored, compliant with the Department's Electronic Messaging Policy (refer to Section 9.1).

12. Correspondence or attachments that are part of the corporate record must be printed out and put on a Records Management paper file or stored electronically in the departmental document management system or other recognised departmental management system such as Mail-In databases.

Approved

Andrew Wood
A/g First Assistant Secretary, CSD

20 October 2000