Community Affairs
Legislation Committee

Examination of Budget Estimates 2001-2002

Additional Information Received

VOLUME 2

Cross portfolio & Outcomes 1 - 9

HEALTH AND AGED CARE PORTFOLIO

AUGUST 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 2001-2002

Included in this volume are answers to written and oral questions taken on notice relating to the estimates hearings on 28 and 29 May 2001

HEALTH AND AGED CARE PORTFOLIO

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000094

WHOLE OF PORTFOLIO

Topic: GST

Hansard Page: CA 94

Senator Crowley asked:

I would like to know where in the annual report – which we will not get for six months – I am going to find the item about how much went out before some came back.

Answer:

The Department is a net GST payer on its services and claims the pay back of these amounts from the Australian Taxation Office (ATO).

There is a one month delay between the submission of the Business Activity Statement (BAS) and the ATO providing a refund. This means that, at 30 June, there is a time lag of reimbursement of one month.

While the Department is not required to disclose total GST paid and refunded within the Annual Report, it is accounted for within the financial statements. A balance will be included in receivables in the balance sheet under Part A (Financial Statements) that represents this amount due back from the ATO at 30 June.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000095

WHOLE OF PORTFOLIO

Topic: GST and SAP

Hansard Page: CA 94

Senator Crowley asked:

(a) Can you put a figure on how much the acquisition (of SAP) for the GST processing is?

(b) Do you know when you purchased it (SAP)?

Answer:

(a) The Department acquired SAP as a complete package and is unable to isolate the cost of the GST processing within the core functionality of the purchasing and accounts receivable modules.

(b) SAP was purchased by the Department in January 2000 and was implemented in December 2000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000096

WHOLE OF PORTFOLIO

Topic: GST

Hansard Page: CA 94

Senator Crowley asked:

If GST to the tune of $1.6 million is registered as 'receipts', is there somewhere else I can find the GST registered as outlays? …… The GST receipts are listed as contributing to the costs or the administrative finances of the department. Where will I find in these documents the amount of GST out?

Answer:

In accordance with Department of Finance guidelines on the presentation of budget estimates all estimates of expenses, assets and appropriation revenue are presented exclusive of recoverable GST. GST receipts and payments are however included in both the budgeted and actual cash flow statements as part *of cash received other* and *cash paid other* respectively. These cash flow figures are contained in the Department's financial statements in both the Portfolio Budget Statements and Annual Report.

These cash flow figures are consistent with the information presented in the Agency Resourcing table at page 281 of Budget Paper No 4 2001-02. As tabled at the Senate Legislative Committee hearings on 28 May 2001 the figure of $64.205m for receipts from independent sources is a cash flow figures and includes $1.6m in GST receipts. These GST receipts are either refunds the Department receives from the ATO on any GST payments it makes, or payments to be remitted to the Australian Taxation Office (ATO) as a result of the issuing of Departmental invoices to its debtors.

Department of Health and Aged Care Forward Year Estimates as at Budget 2001-02

ADMINISTERED EXPENSES

	Budget 2001/02 ($m)	Forward Estimate 2002/03 ($m)	Forward Estimate 2003/04 ($m)	Forward Estimate 2004/05 ($m)
Outcome 1: Population Health and Safety				
Appropriation Bill 1	114.252	111.918	161.077	162.349
Appropriation Bill 2	171.603	194.079	154.059	157.509
Special Appropriation				
National Health Act 1953 - Essential Vaccines	86.902	86.158	83.977	85.650
	372.757	***392.155***	***399.113***	***405.508***
Outcome 2: Access to Medicare				
Appropriation Bill 1	432.329	468.558	504.741	596.901
Appropriation Bill 2	97.222	92.466	31.273	35.999
Special Appropriation				
Health Insurance Act 1973 - Medical Benefits	7,718.607	8,205.453	8,536.744	8,941.566
National Health Act 1953 - Pharmaceutical Benefits (concessional)	3,371.095	3,710.502	4,058.013	4,424.149
National Health Act 1953 - Pharmaceutical Benefits (general)	791.114	868.573	958.797	1,065.204
National Health Act 1953 - Pharmaceutical Benefits (other)	402.427	446.086	487.746	483.736
National Health Act 1953 - Aids and Appliances (p)	59.301	64.292	69.312	77.607
Health Care Appropriation Act 1998 – National Health Development - Special Assistance	66.576	61.823	50.560	50.560
Health Care Appropriation Act 1998 - Australian Health Care Agreements - provision of designated health services	6,517.868	6,917.977	7,309.251	7,751.928
	19,456.539	***20,835.730***	***22,006.437***	***23,427.650***
Outcome 3: Enhanced Quality of Life for Older Australians				
Appropriation Bill 1	203.543	203.534	198.806	201.788
Appropriation Bill 2	659.217	711.740	768.476	829.712
Special Appropriation				
Aged Care Act 1997 - Community Care Subsidies	248.444	263.117	278.131	293.091
Aged Care Act 1997 - Flexible care subsidies	43.978	46.541	48.600	50.009
Aged Care Act 1997 - Residential care subsidies	3,738.695	3,931.175	4,073.555	4,244.832
	4,893.877	***5,156.107***	***5,367.568***	***5,619.432***
Outcome 4: Quality Health Care				
Appropriation Bill 1	406.328	414.097	428.340	393.082
Appropriation Bill 2	88.849	77.366	76.040	76.233
Special Appropriation				
National Health Act 1953 - Aids and Appliances (p)	34.237	34.340	35.064	35.800
National Health Act 1953 - Blood Fractionation, products and blood related products	94.567	94.919	94.920	151.905
Health Care Appropriation Act 1998 - Australian Health Care Agreements - provision of designated health services	106.325	110.210	114.324	118.586
	730.306	***730.932***	***748.688***	***775.606***

Outcome 5: Rural Health Care				
Appropriation Bill 1	107.507	132.641	150.761	153.955
	107.507	***132.641***	***150.761***	***153.955***
Outcome 6: Hearing Services				
Appropriation Bill 1	151.858	158.659	163.397	170.063
	151.858	***158.659***	***163.397***	***170.063***
Outcome 7: Aboriginal and Torres Strait Islander Health				
Appropriation Bill 1	203.207	226.474	252.590	259.580
	203.207	***226.474***	***252.590***	***259.580***
Outcome 8: Choice Through Private Health				
Appropriation Bill 1	13.312	6.609	8.800	13.323
Special Appropriation				
Private Health Insurance Rebate	1,924.864	2,030.435	2,148.784	2,273.386
	1,938.176	***2,037.044***	***2,157.584***	***2,286.709***
Outcome 9: Health Investment				
Appropriation Bill 1	431.727	456.351	457.737	455.580
Appropriation Bill 2	10.000			
	441.727	***456.351***	***457.737***	***455.580***
Total Administered Expenses	**28,298.674**	**30,128.813**	**31,703.895**	**33,554.103**
Total Departmental Expense	**693.211**	**682.481**	**677.029**	**674.594**
Total	**28,991.885**	**30,811.294**	**32,380.924**	**34,228.697**

SUMMARY OF MAJOR PROGRAMS - SPECIAL APPROPRIATIONS

Medical Benefits	7,718.607	8,205.453	8,536.744	8,941.566
Pharmaceutical Benefits	4,564.636	5,025.161	5,504.556	5,973.089
Australian Health Care Agreements	6,624.193	7,028.187	7,423.575	7,870.514
Aged Care - Residential Subsidies	3,738.695	3,931.175	4,073.555	4,244.832
Private Health Insurance Rebate	1,924.864	2,030.435	2,148.784	2,273.386

Page 281 Budget Paper No. 4 2001-02
Health and Aged Care Portfolio

Newly allocated.

Receipts from independent sources	Departmental receipts $'000	GST component $'000	Administered receipts $'000	GST component $'000
Outcome 1	53,498	1,670	9,615	6,220
Outcome 2	2,040	1,522	56,941	36,881
Outcome 3	3,927	2,746	31,299	20,272
Outcome 4	1,607	1,228	52,614	34,078
Outcome 5	372	303	6,619	4,287
Outcome 6	387	280	8,950	5,797
Outcome 7	839	626	3,630	2,351
Outcome 8	457	403	17,682	11,453
Outcome 9	1,078	876	28,119	18,213
	64,205	9,654	215,469	139,559

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E0100069

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: CLONING BY SOMATIC CELL NUCLEAR TRANSFER

Written Question on Notice

Senator Harradine asked:

(a) Given that there are scientific concerns about the epigenetic affects of cyto-plasmic transfer including of the mitochondria and their DNA, does the Department consider it important to bring this form of genetic modification within the scope of the Gene Technology Act?

(b) Given the high rate of failure of somatic cell nuclear transfer, and the evidence of a high rate of abnormality and even fatal abnormality, does the Department consider that somatic cell nuclear transfer in animals and in humans should be brought within the scope of the Gene Technology Act?

Answer:

Somatic cell nuclear transfer is explicitly excluded from the scope of the *Gene Technology Act 2000*. This is because somatic cell nuclear transfer is not considered to involve the modification of genes. The epigenetic effects, including developmental abnormalities observed in animals cloned by this procedure, are also not considered to be a result of genetic modification.

However, while the Gene Technology Act 2000 is not considered to be the appropriate legislative vehicle to address the safety and ethical issues surrounding cloning and assisted reproductive technologies generally, there is a recognition by all Australian Governments that purpose specific legislation may be required. At its tenth meeting on 8 June 2001, the Council of Australian Governments (CoAG) committed itself to achieving nationally consistent provisions in legislation to prohibit human cloning and to working towards nationally consistent provisions to regulate assisted reproductive technology and related emerging human technologies. CoAG has sought a report from Health Ministers by the end of the year on technical issues with the aim of a nationally consistent approach being in place in all jurisdictions by June 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000070

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: POSTINOR-2/Levonorgestrel

Written Question on Notice

Senator Harradine asked:

(a) Re. the morning-after pill Postinor 2 (refer CA 23, Feb 19, 2001). Could Dr Hunt provide information on the drug's action as preventing implantation? Could Dr Hunt advise as to whether the pill also acts after implantation?

(b) When is the TGA expected to make a decision on the application to register Postinor-2 for use in Australia?

(c) Is the National Drugs and Poison Schedule Committee currently in receipt of or considering any application to reschedule levonorgestrel from schedule 4 of the Standard for the Uniform Scheduling of Drugs and Poisons so that it could be available from pharmacists without prescription?

(d) If such an application is received what is the process involved? Who makes the decisions? Is there a public consultation phase?

Answer:

(a) The precise mode of action is not known. It has been postulated that the mechanism of action of Postinor-2 is due to combined effects on pituitary-ovarian function, endometrium and cervical secretion. However, the TGA has no evidence to suggest that Postinor-2 acts after implantation.

(b) The TGA expects to make a decision on the application to register Postinor-2 in the last quarter of 2001.

(c) No

(d) (i) Scheduling/rescheduling applications must be submitted in accordance with the NDPSC Guidelines. These guidelines are publicly available on the TGA website (http://www.health.gov.au/tga/docs/pdf/ndpscg.pdf). If an application to reschedule levonorgestrel is received and meets the NDPSC requirements, it would be assessed and referred for consideration at the next available NDPSC meeting.

(ii) NDPSC decisions are made by a majority vote of members present at the meeting, which must also include a majority vote of jurisdictional members.

(iii) Yes. NDPSC pre- and post-meeting public consultation phases are prescribed in the Therapeutic Goods Regulations 1990 (as amended). In summary, the NDPSC is required to publish a notice in the Government Gazette before and after each meeting which includes an invitation to make public submissions. All public submissions received in accordance with the Regulations must be considered by the NDPSC. The pre-meeting Gazette notice lists, among other matters, the substances to be considered at the NDPSC meeting, while the post-meeting Gazette notice contains the outcomes, including scheduling decisions. Post-meeting public submissions can only be made by persons who made a pre-meeting public submission and where the NDPSC decision results in an amendment to the Poisons Standard for that particular substance. Where a post-meeting submission is received, the NDPSC, at the next available meeting, must confirm, vary or set aside the amendment. If the amendment is set aside, it is replaced with a new scheduling decision, which is then subject to post-meeting public consultation processes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000068

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: IMPLANTABLE CONTRACEPTIVES

Hansard Page: CA 146-147

Senator Harradine asked:

(a) Is the Department aware of the known adverse effects of Implanon on women's health?

(b) Is the Department aware that after 30 months Implanon has a known abortifaceint action?

(c) And, if so, what steps will be taken to ensure that women are fully informed of this abortifacient effect?

(d) Is the Department aware of the significant numbers of law suits relating to Norplant, a long-term contraceptive implant similar to Implanon, that have resulted in the withdrawal of Norplant from the market in several countries, including the United Kingdom?

(e) Are you aware that at its introduction, Norplant was also hailed as a safe long-term contraceptive when first introduced into the United Kingdom? What is the possibility of law suits in respect of Implanon in Australia?

Answer:

(a) The TGA is aware of the adverse effects mentioned by Senator Harradine. These possible adverse effects are listed in the Australian prescribing information for health practitioners (PI) and in a consumer medicine information document (CMI).

(b-c) The TGA is not aware of Implanon having an abortifaceint action after 30 months and therefore there are no warnings of abortifacient action in the Implanon PI and CMI.

(d) Norplant is a sub-dermal contraceptive implant containing levonorgestrel, whereas Implanon is a sub-dermal contraceptive implant containing etonorgestrel.

Norplant has never been registered in Australia.

The TGA is unable to substantiate the claim that a significant number of lawsuits have been initiated overseas in relation to Norplant or that Norplant has been withdrawn from several countries, including the UK. The TGA would take into account the foreign status of Norplant in the event that it was proposed for registration in Australia.

(e) The TGA is unable to comment on claims of quality, safety and efficacy of Norplant since an application for this product has never been reviewed by the TGA.

The Department of Health and Aged Care notes that Australians may commence civil proceedings against any pharmaceutical company in regard to any one of their products. This could include Implanon's sponsor, Organon (Australia) Pty Ltd.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000102

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FAMILY PLANNING

Written Question on Notice

Senator Harradine asked:

Please provide allocations approved for family planning agencies for 2000-2001 including payments direct from the Commonwealth and payments via State/Territory Governments through the Public Health Outcome Funding Agreements (PHOFAs).

Answer:

The Minister approved the following funding allocations for the organisations funded under the Family Planning Program for 2000-2001:

Family Planning Australia	$ 89,224
FP Health, NSW	$4,741,214
FP, Vic	$1,741,716
FP, QLD	$2,727,530
FP, WA	$1,557,412
FP, TAS	$ 509,506
FP, NT	$ 361,204
Working Women's Health	$ 101,430
Australian Catholic Bishops	$ 818,463
Pregnancy Support Services	$ 225,108
TOTAL	$12,872,808

Funding of $1.9 million is also provided for family planning activities through the Public Health Outcome Funding Agreements for the ACT and SA. Of this SA received $1.463 million and the ACT received $.442 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000103

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TALKING SEXUAL HEALTH DOCUMENT

Written Question on Notice

Senator Harradine asked:

(a) Are there any plans to develop national standards for the inclusion of sexuality education materials in school-based programs?

(b) Are there any proposed costings for such materials?

(c) Would independent schools be required to use the materials?

(d) Would such materials include teaching on abstinence and tools for young people to help them say no to sexual pressure and premature sexual activity?

Answer:

(a) The Department of Health and Aged Care has produced a limited range of sexuality education resources, as distinct from national standards, for school-based programs. The *Talking Sexual Health Framework* is one such resource developed for both government and non-government secondary schools. The *Framework* has been made available to education authorities in each state and territory as a guideline for the implementation of education about sexually transmissible infections (STIs), HIV/AIDS and blood-borne viruses (BBVs) in secondary schools. Schools may choose to implement the guidelines or they may choose not to. It is not the role of the Department to prescribe compulsory curriculum to schools.

(b) There are no such costings. See response to (a).

(c) See response to (a).

(d) Education resources produced by the Department of Health and Aged Care for young people addressing sexuality are targeted at those young people who are already sexually active. These resources do however present young people with a range of perspective's and options, including confirmation that not all young people are sexually active and abstinence as a valid choice and as well as a means of preventing the transmission of sexually transmissible infections.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000124

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TERMINATION OF PREGNANCY - COMMONWEALTH LIABILITY

Written Question on Notice

Senator Harradine asked:

In the event of a patient experiencing adverse sequelae following a drug-induced abortion, would the Commonwealth be legally liable for advising doctors to use drugs for a purpose for which they have not been approved?

Answer:

The decision to prescribe a medicine is taken by a registered medical practitioner, the Commonwealth does not regulate the practice of medicine; this is regulated by the States and Territories. Therefore, any legal redress would need to be sought against the particular medical practitioner for breach of their duty of care to the patient.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000125

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: MISOPROSTOL

Written Question on Notice (HIC)

Senator Harradine asked:

(a) Is Misoprostol an authority required drug under the Schedule of Pharmaceutical Benefits effective 1 February 2001.

(b) If so, does this mean that a doctor seeking authority to prescribe Misoprostol to terminate a patient's pregnancy could not lawfully be given that authority by the HIC unless he/she told the HIC that he/she intended to use the drug to treat her ulcer, which would be a 'false or misleading statement' under the National Health Act 1953 section 103(5)g, carrying a penalty of a $5,000 fine or 2 years in prison or both?

(c) Is the drug Misoprostol being used at present by any doctors in Australia for terminating pregnancies?

(d) If so, has the HIC unlawfully given the required authority to doctors who tell the HIC that they intended to use it to terminate pregnancies, or have doctors made false and misleading statements to HIC?

Answer:

(a) Yes.

(b) Yes.

(c) HIC is unaware of whether Misoprostol is being used by any doctors in Australia for termination of pregnancies.

(d) not applicable

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000101

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: ALCOHOL EDUCATION AND REHABILITATION FOUNDATION

Written Question on Notice

Senator Harradine asked:

Re the new Alcohol Education and Rehabilitation Foundation which will "focus on preventing alcohol and licit substance abuse, especially in vulnerable populations through treatment, rehabilitation, research and community based education programs".

In regard to rehabilitation, will the new funding improve availability and access to rehabilitation services, to avoid the waiting times for admission which can contribute to a person with alcohol problems continuing their addictive behaviours?

Answer:

Details of the funding arrangements for the Alcohol Education and Rehabilitation Foundation have not yet been finalised. Legislation is currently being drafted which will require the Foundation to adhere to agreed objectives and to enter into an agreement with the Commonwealth regarding, inter alia, broad expenditure patterns for the allocated funding.

One of the Foundation's major objectives will be to provide funding grants to organisations with appropriate community linkages to deliver alcohol prevention, education, treatment and rehabilitation services, particularly to vulnerable groups such as indigenous Australians and youth. Total funding available is $115 million over 4 years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000098

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TOTAL COMMONWEALTH FUNDING ALLOCATED TO DRUG AND ALCOHOL CAMPAIGNS

Written Question on Notice

Senator Lees asked:

How much funding has been allocated to alcohol and drug programs by the Commonwealth, under all relevant programs, including Tough on Drugs, PHOFA and law enforcement programs, for the next three financial years, compared with the last three financial years? And what is the breakdown between treatment and rehabilitation programs, education programs and law enforcement activities?

Answer:

Funding for national drug and alcohol programs administered by the Department of Health and Aged Care forms part of the National Population Health Program and is administered through a one-line appropriation. This one-line appropriation includes any additional Commonwealth Budget allocations, e.g. the National Illicit Drug Strategy (NIDS).

Additional funding is also provided to State/Territory Governments for drugs programs under the broadbanded Public Health Outcome Funding Agreements (PHOFAs). The PHOFAs are designed to enable States and Territories to allocate Commonwealth assistance in relation to a range of national population health strategies according to local needs and priorities, within the context of the agreed national priorities.

Drug and alcohol programs are also administered by other Commonwealth agencies (eg: law enforcement and school drug education). This Department is unable to provide information on funding for these programs and a breakdown between treatment and rehabilitation programs, education programs and law enforcement activities is therefore not possible.

Other additional Commonwealth Budget allocations to the Department of Health and Aged Care have been provided:

- As part of the National Illicit Drug Strategy (NIDS) *"Tough on Drugs",* launched by the Prime Minister in November 1997, funding of $263.8 million was allocated for a range of demand reduction measures.
- $6.1 million over three years in the 1998-99 Budget for tobacco harm minimisation initiatives. This funding includes money for the development of a number of policy initiatives under the National Tobacco Strategy.

- $4.0 million over 4 years in the 2000-01 Budget for alcohol harm minimisation initiatives. This funding includes money for the development of a number of policy initiatives under the National Alcohol Strategy and implementation of the National Health and Medical Research Council (NHMRC) Australian Drinking Guidelines.

The Commonwealth Government is also providing $115m over four years (from 2001-02) to enable the Alcohol Education and Rehabilitation Foundation to fund programs and activities aimed at preventing and reducing the harm caused by misuse of alcohol and other licit substances. The Foundation will support evidence-based treatment, rehabilitation, research and prevention programs as well as community education programs.

Funding over the next three financial years from the population health appropriate, on top of funds provided for new policies, will be at the discretion of the Minister for Health and Aged Care.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000099

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: METHADONE

Written Question on Notice

Senator Lees asked:

What role does the Commonwealth have in monitoring the manner in which methadone is prescribed or administered? Are national guidelines in place and through what avenues are such guidelines assessed and reported upon?

Answer:

The Commonwealth Government does not directly fund or administer methadone programs, nor does it have a direct role in how States and Territories manage the delivery of methadone services.

States and Territories are responsible for the conduct of methadone programs. Each jurisdiction has guidelines and procedures for prescribing and administering methadone. The National Expert Advisory Committee on Illicit Drugs (NEACID) is in the final stages of drafting National Methadone Guidelines. States and Territories require general practitioners and pharmacists to undertake training before they are registered as methadone prescribers/dispensers.

NEACID is also developing national assessment procedures for medical practitioners seeking authorisation to engage in methadone maintenance treatment. The aim of the procedures is to determine whether medical practitioners have met specified learning objectives sufficiently to be authorised to engage in methadone maintenance treatment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000100

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: PETROL SNIFFING PROGRAMS

Written Question on Notice

Senator Lees asked:

What progress has been made on the implementation of petrol sniffing programs in the Northern Territory?

Answer:

A number of Commonwealth-funded projects aimed at addressing petrol sniffing are under way in both the Northern Territory, and in Central Australia more generally, through the National Illicit Drug Strategy and the Office for Aboriginal and Torres Strait Islander Health.

National Illicit Drug Strategy

Under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program, the Government has provided funding totalling $8.3 million towards the establishment or expansion of eighteen (18) services specifically targeting illicit drug use within Aboriginal and Torres Strait Islander communities.

Of these 18 services, funding totalling $1.9 million over four years has been allocated to three services targeting petrol sniffing within Australia. Funding of $810,000 (1998/99 to 2002/03) has been provided to the Ngaanyatjarra Pitjanjatjara Yankunytjajara (NPY) Women's Council Aboriginal Corporation to establish a tri-State (Northern Territory, Western Australia and South Australia) community based petrol sniffing project in member communities utilising a case management community development model to work with petrol sniffers and their families.

Through the National Illicit Drug Strategy Community Partnerships Initiative, the Government has provided funding of over $1 million towards the establishment of thirteen (13) community prevention programs for Aboriginal and Torres Strait Islander communities, many of which have a petrol sniffing component. Four of these projects were funded in the Northern Territory.

Office for Aboriginal and Torres Strait Islander Health (OATSIH)

The OATSIH will contribute funds totalling $717,019 during the current year (2000/01) towards petrol sniffing programs within Central Australia. This includes the following projects in the Northern Territory:

- funding of over $216,000 to the Intjartnama Aboriginal Corporation to operate an outstation program for petrol sniffers and other young people at risk;
- funding of more than $110,000 to the Ilpurla Aboriginal Corporation to operate an outstation rehabilitation program for petrol sniffers;
- funding of $219,000 to the Mount Theo Yuendumu Substance Misuse Aboriginal Corporation to operate both an outstation rehabilitation and diversion program for petrol sniffers and town-based youth programs; and
- non-recurrent funding of almost $172,000 to the Ngaanyatjarra Pitjantjara Yankunytjatjara (NPY) Women's Council to expand existing activities/services to incorporate the community of Amata (SA).

A review of the three OATSIH funded petrol sniffing programs at Intjartnama, Ilpurla and Mt Theo/Yuendumu will commence shortly to assess the effectiveness and efficiency of the petrol sniffing programs in place.

The OATSIH has contributed funding of $25,000 this financial year to the production and dissemination of the *Petrol Sniffing and Other Solvents* Manuals developed by the Aboriginal Drug and Alcohol Council SA Inc. The Manuals are a hands-on tool directed at the community level to assist with approaches to reduce the incidence and harm resulting from petrol sniffing behaviours.

Petrol Sniffing Diversion Project

The petrol sniffing diversion project is aimed at diverting primarily young experimental petrol sniffers, and those at risk of petrol sniffing, into community supported early intervention and prevention initiatives. The project involves a partnership between the Federal Government, the Northern Territory Government and community-based service providers.

Funding will be up to $1 million from the $2.7 million of Commonwealth funding available to the Northern Territory under the *Tough on Drugs* Diversion Initiative. Funding will be for the period to 30 June 2003.

The project will be developed initially as a pilot and, subject to a satisfactory evaluation after 12 months, the project would then be rolled out progressively within Aboriginal communities where petrol sniffing and inhalant use is a problem.

A Volatile Substance Misuse Working Group has been set up to implement this initiative. The group comprises relevant Commonwealth and Territory Government agencies and non-government representatives including the Aboriginal Medical Services Alliance of the Northern Territory (Community Controlled Aboriginal Health services), the Central Australian Aboriginal Congress, the Australian National Council on Drugs and the Cooperative Research Centre for Aboriginal and Tropical Health. The Working Group has decided to fund two pilot projects: one in the north of the Territory and the other in the Central Australian region.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000045

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN NATIONAL COUNCIL ON DRUGS

Hansard Page: CA 79-80

The answers to these questions have been provided by the Australian National Council on Drugs (ANCD).

Senator Faulkner asked:

(a) Do you have a breakdown of [Australian National Council on Drugs expenditure] for us? Could it be broken down into main areas?

(b) Could [the Committee have] the details of [the Australian National Council on Drugs overseas travel] expenditure?

(c) Are council members paid sitting fees …[at] a Remuneration Tribunal determined rate? [Please provide] the rate and perhaps indicate the monies that have been paid to council members.

Answers:

(a) As reported in the Australian National Council on Drugs (ANCD) Annual Report for 1999/00, the ANCD expenditure for the 1999/00 financial year was as follows:

	$
Secretariat Salaries	141,779
Secretariat Activities	67,708
ANCD Commissioned Research	44,330*
All ANCD Meeting Costs	141,793
Administrative Support for the Chair	36,177
Additional ANCD Members' Expenses	96,022
Media and Promotions	5,470
TOTAL	533,279

* Does not include over $555,640 in commitments that are due for payment upon completion of commissioned projects, expected to occur over the next two financial years.

(b) The total cost of Australian National Council on Drugs overseas travel for 1999/00 was $8,291.40.

(c) Australian National Council on Drugs members are paid sitting fees. The rates are set to those determined by the Remuneration Tribunal and are as follows:

Sitting Fees

Office	Category 2
Chairperson	$340.00 per day
Other Members	$260.00 per day

In 1999/00 sitting fees totalling $54,655 were paid to members of the Council.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000046

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN NATIONAL COUNCIL ON DRUGS

Hansard Page: CA 80

The Australian National Council on Drugs (ANCD) has provided the answer to this question.

Senator Denman asked:

Could you also give us a run-down on how many trips overseas Brian Watters has had compared with the other members [of the Australian National Council on Drugs].

Answer:

In 1999/00 there was one overseas trip undertaken by Mr Watters on behalf of the Australian National Council on Drugs. This was the only overseas trip funded by the ANCD.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000047

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS CAMPAIGN – PARENT BOOKLET

Hansard Page: CA 80

Senator Faulkner asked:

Can you tell me when the parent booklet [*Our Strongest Defence Against the Drug Problem*] was printed, please [precise date]?

Answer:

Commenced Print NSW:	27/2/01
Commenced Print VIC:	28/2/01

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000048

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS CAMPAIGN – PARENT BOOKLET

Hansard Page: CA 81-82

Senator Faulkner asked:

(a) Were you able to source the paper for this document [the parent booklet] in Australia?

(b) Does the department have a policy in relation to this?

(c) If the paper was not sourced in Australia, could you also provide a brief explanation of why that was not the case?

(d) You might indicate where it was sourced from if it was not sourced from Australia.

Answer:

(a) Yes.

(b) No.

(c) See above answer to (a).

(d) See above answer to (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000049

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS CAMPAIGN – PARENT BOOKLET

Hansard Page: CA82

Senator Faulkner asked:

Were there any storage costs [for the parent booklet in advance of the distribution]?

Answer:

While there were not any storage costs charged after the booklet was printed, the paper stock for the booklet was purchased in 2000 and stored at a cost of $62,000 prior to printing the booklet.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000050

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS CAMPAIGN – PARENT BOOKLET

Hansard Page: CA 82 - 83

Senator Faulkner asked:

Would [you] be able to share the results of [the comprehensive] evaluation [of the campaign when it becomes available in August] with the committee.

Answer:

Yes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000051

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AVAILABILITY OF DRUG TREATMENT

Hansard Page: CA 86

Senator Gibbs asked:

(a) Could you let me know how many places are available for treatment of drug addiction. Could they be identified as illicit-drug treatment centres and other drug treatment centres—that is, the licit drugs: tobacco, alcohol, the ones that are quite legal to use.

(b) I would like to know how many methadone maintenance places are there, and how many abstinence oriented places there are?

(c) I would also like to know what is the demand for such services, and what is the shortfall?

(d) I would also like to know whether the government is planning to take action to overcome shortfalls?

(e) I am just wondering if the Commonwealth government does have a strategy in mind?

Answer:

(a) State and Territory Health Departments have primary responsibility for the provision of drug and alcohol services. The Commonwealth does not have a consolidated list of all the drug treatment places provided by all jurisdictions.

In 1999/2000 a total of 19,276 episodes of care were provided under the National Illicit Drug Strategy Non Government Organisation Treatment Grants Program. The program provides funding for non-government organisations to establish and operate new treatment services and expand or enhance existing treatment services for treating illicit drug problems. The range of projects funded includes outreach support, outpatient counselling, inpatient and outpatient detoxification and medium to long term rehabilitation.

(b) The Department of Health and Aged Care does not collect information on the number of methadone places currently available in each State/Territory. At 30 June 2000, there were 30,237 people on the methadone program across Australia. The Department does not have information on the number of abstinence oriented places.

(c) Drug treatment services are provided by a range of public sector and non-government organisations. Some are government funded, some are charitable organisations or not for profit incorporated bodies, and some are 'for profit' organisations. There is no one mechanism that collects information on all these types of services and on waiting lists for any particular service.

(d) As part of the National Illicit Drug Strategy the Government has allocated $57 million over 4 years to 133 non-government treatment services.

(e) See answer to (d). above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000052

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: ALCOHOL AND OTHER DRUG SERVICES - OPERATION

Hansard Page: CA 87

Senator Gibbs asked:

Is it possible for a person with no qualifications to actually open and operate a drug rehab centre? Are there restrictions?

Answer:

State and Territory Health Departments have primary responsibility for the provision of drug and alcohol services in their jurisdiction, and accordingly, they determine the criteria for funding treatment services, including qualifications required to open and operate a drug rehabilitation service. The type of qualification required by staff depends on the service being provided.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000053

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic**:** ILLICIT DRUG TREATMENT - PHARMACOTHERAPIES

Hansard Page: CA 88

Senator Gibbs asked:

Will we be able to have a copy of the evaluation report of various pharmacotherapy approaches which will be tabled at the Ministerial Council on Drug Strategy meeting at the end of July?

Answer:

A final report of the National Evaluation of Pharmacotherapies for Opioid Dependence (NEPOD) will be considered by the Ministerial Council on Drug Strategy at its meeting on 31 July 2001. A copy of the report will be provided to the Committee after its release.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000054

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL DRUG AND ALCOHOL RESEARCH CENTRE REPORT – TREATMENT SERVICES

Hansard Page: CA 89

Senator Gibbs asked:

Are there evaluations of the different treatment centres? Some centres are quite forward thinking and other centres work on abstinence.

Answer:

The National Drug and Alcohol Research Centre has researched this issue and a copy of the Report titled "Investing in Drug and Alcohol Treatment" will be sent to the Committee Secretariat.

The Executive Summary can be accessed at
www.med.unsw.edu.au/ndarc/publications/techreport91.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000055

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: INTERCEPTION OF DRUGS BY AFP

Hansard Page: CA 92

The answer to this question was provided by Australian Federal Police (AFP).

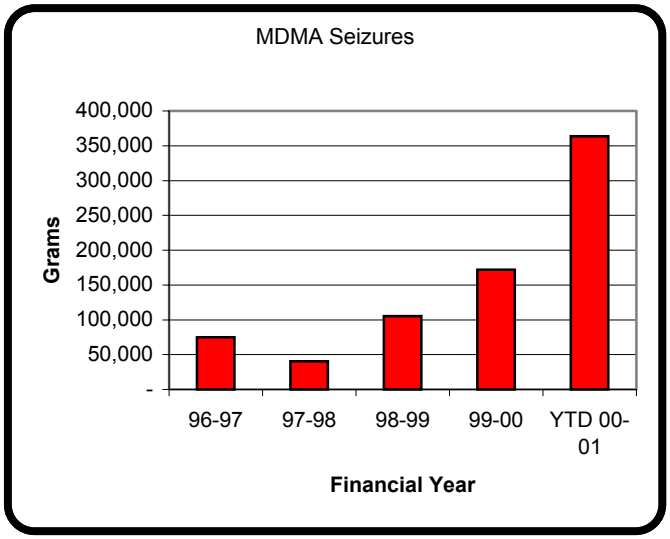
Senator Gibbs asked:

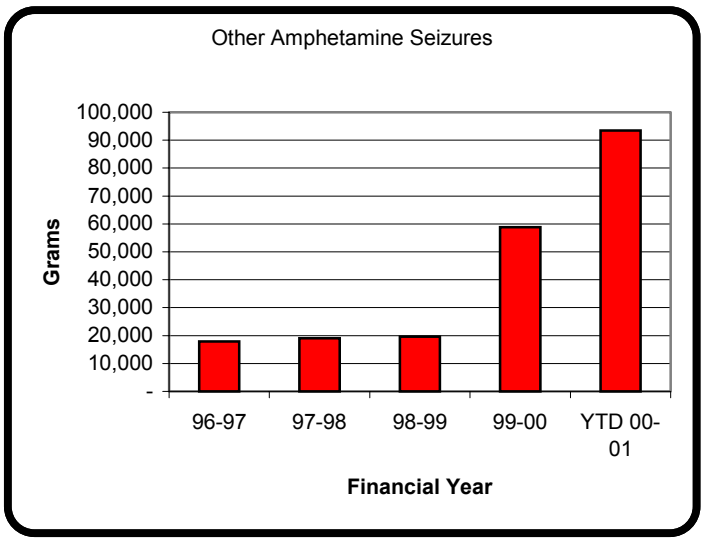
How much (heroin, cocaine and amphetamines by weight amount) do the Federal Police intercept?

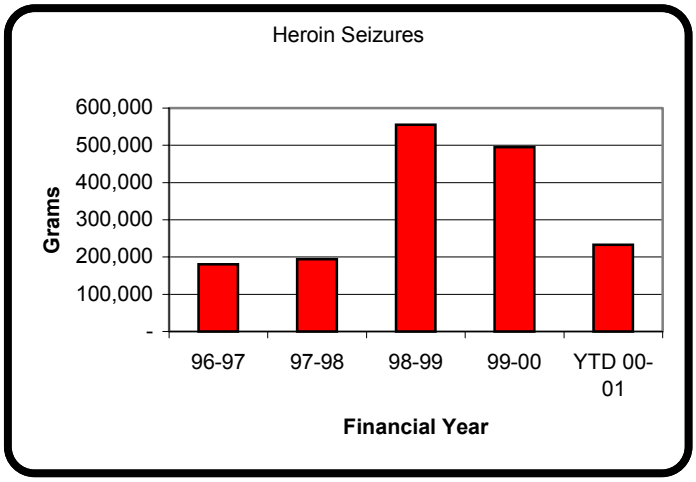
Answer:

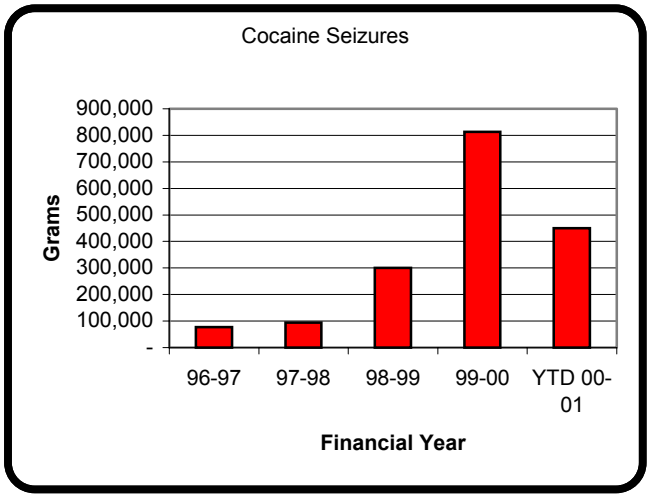
Between 2 November 1997 when National Illicit Drug Strategy (NIDS) funding commenced and 30 April 2001, the AFP has been involved in the seizure of 1680 kilograms of heroin, 1520 kilograms of cocaine, 736 kilograms of MDMA and 458 kilograms of other amphetamine type stimulants in operations in Australia and overseas.

The attached graphs depict drug seizures within Australia for financial years 1996-97 to 2000-01 (current 1 June 2001).









Notes:

1) All figures are in grams
2) The figures include seizures awaiting analysis to confirm both the weights and the presence of the illegal substance
3) Net weight 'confirmed' has been used where available, followed by net weight 'estimated', followed by gross weight 'confirmed', followed by gross weight 'estimated'.
4) These graphs depict domestic seizures by the Australian Federal Police, the Australian Customs Service and the Joint Asia Crime Group (comprising officers from the AFP, ACS, National Crime Authority, NSW Police and the NSW Crime Commission) where the drugs have been held in AFP custody. Seizures made by the NCA itself are not included.

Source: PROMIS as at 1 June 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000056

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL INFLUENZA VACCINE PROGRAM

Hansard Page: CA95

Senator West asked:

How much wastage [of the vaccine occurred in Victoria and South Australia during the piloting of the National Influenza Vaccine Program for Older Australians]?

Answer:

Victoria

In 1997 when the Department of Human Services, Victoria agreed to conduct a pilot study for the Commonwealth in the lead up to the National Influenza Vaccine Program for older Australians. The combined level of leakage and wastage was 1.4% of the total vaccine distributed with a total of 71.3% of the cohort vaccinated. The Pharmacy Guild distributed the vaccines to doctors on an imprest arrangement. The agreement the Victorian DHS arrived at was that the wholesale price of the vaccine would be paid plus a $3.00 delivery fee per vaccine. This equated to a total cost of $15.00 per vaccine distributed.

South Australia

In 1998, South Australians aged 70 years and over (some 137,000 people) were eligible for free influenza vaccine. Under the program, the free influenza vaccine was distributed direct to general practitioners' surgeries and to nursing homes.

- 142,000 doses of 'flu vaccine were distributed in SA to service providers in 1998.
- One stocktake survey was conducted seven weeks into the program. A sample of general practitioners and other providers was requested to supply details of vaccine stocks still held at that time. Data were collected on wastage due to cold-chain and other failures.
- Results of the stocktake program were:
  - wasted (destroyed, reported cold chain failure or expired) – estimated 0.4% of doses distributed.
- The SERCIS survey for 1998 showed that 67% of people over the age of 65 years received a 'flu vaccine.
- No wastage data were collected at the end of the program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000057

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: COST BENEFIT ANALYSIS OF THE NATIONAL INFLUENZA VACCINE PROGRAM

Hansard Page: CA96

Senator West asked:

What I would like is a copy of the cost-effectiveness work [in relation to prescriptions and wastage] that you have done….

Answer:

An assessment by the Department of cost benefits associated with the delivery of influenza vaccine via the National Immunisation Strategy (NIS) Program Model versus the pre-existing access to influenza vaccines via the Pharmaceutical Benefits Scheme (PBS) has been undertaken. Under the PBS, eligible people at special risk of adverse consequences from infections of the lower respiratory tract were required to attend their general practitioner, obtain a prescription for dispensing at a pharmacy, and follow up with a subsequent visit to a general practitioner for the vaccine to be administered.

Under the free Influenza Program for Older Australians, people aged 65 years and over are required to attend a general practitioner to have the vaccine administered at a single visit. No prescription is required.

Attachment 1 sets out the estimated savings to the Commonwealth from this approach. You will note that the savings range from $4,051,536 based on the assumption that 40% of GP's charge for a second associated consultation to perform vaccination to $11,972,496 based on the assumption that 80% of GP's charge for the second consultation.

The cost to the Commonwealth under the Influenza Program for Older Australians are also reduced due to renegotiation of a lower national purchase price for vaccines.

The Influenza Program for Older Australians was externally evaluated after the first year of operation. The Evaluation included an assessment of the relative cost benefits of four options of program delivery, a proposal submitted by the Pharmacy Guild of Australia which involved GPs receiving vaccine from pharmacists via an imprest arrangement, a separate method of distribution for the Indigenous Influenza Vaccine Program, such as the Pharmacy Guild proposal, delivery by a single, national supplier (such as a vaccine manufacturer) and the existing National Influenza Scheme (NIS) which includes the National Influenza Vaccine Program for Older Australians and the National Indigenous Influenza and Pneumococcal Vaccine Program.

Tables showing the cost to the Commonwealth of the NIS and the proposed Pharmacy Guild of Australia proposal prepared by the consultant are attached (Attachment 2).

While the evaluation found that there was an increase in leakage and wastage of vaccine, the NIS Program continued to be the most cost effective option. In addition, the consultant found that the program offered additional benefits in terms of improved patient access and an integrated delivery system. The Evaluation concluded that the preferred approach was to continue with the NIS Model while regularly monitoring both leakage and wastage.

Overall the 'one-stop' option for older Australians was found to be the most efficient means of delivering the vaccine to the group due to the simplified scheme. This is supported by continued improvement of vaccine coverage from less than 65 % prior to the National Immunisation Strategy Program to 74% in 2000.

Assumed proportion of GPs who charge for second visit:

		80%		60%		40%	
NIS Model							
	GP visits	$41,647,200		$41,647,200		$41,647,200	
	Fluvax	$23,860,080		$23,860,080		$23,860,080	
			$65,507,280		$65,507,280		$65,507,280
PBS model							
	GP First visit	$41,647,200		$41,647,200		$41,647,200	
	GP second visit	$15,841,920		$11,881,440		$7,920,960	
	Vaccine	$19,990,656		$19,990,656		$19,990,656	
			$77,479,776		$73,519,296		$69,558,816
Difference			($11,972,496.00)		($8,012,016.00)		($4,051,536.00)
		NIS approach minimises cost in this scenario		NIS approach minimises cost in this scenario		NIS approach minimises cost in this scenario	

Question: E01000057
ATTACHMENT 2

Tables showing cost to the Commonwealth of the Older Australians Program and the proposed Pharmacy Guild proposal

Source: *Evaluation of the Influenza Vaccine Program for Older Australians and the National Indigenous Pneumococcal and Influenza Immunisation Program.* Mandala Consulting in association with David Lowe Consulting, Jill Hardwick Consulting and Margaret Hayes-Hampton. February, 2000

Table 1 Cost to the Commonwealth of the Pharmacy Guild proposal to distribute influenza vaccine

	Cost											
	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m	$m.
Coverage rates												
70%	21.597			21.597			21.597					
75%		23.14			23.14			23.14				
80%			24.683			24.683			24.683			
										21.597		
Wastage/leakage											23.14	
10%				3.085	3.085	3.085						24.683
15%							4.628	4.628	4.628			
20%										6.171	6.171	6.171
No. of doctor visits												
0.5												
1	33.821	36.237	38.653	33.821	36.237	38.653	33.821	36.237	38.653	33.821	36.237	38.653
1.5												
Total	55.418	59.377	63.336	58.503	62.462	66.421	60.046	64.035	67.964	61.589	65.548	69.507
Assumptions:												
Non Aboriginal and Torres Strait Islander population over 65 years: 2,300,776												
Cost of vaccine per dose: $13.41												
Cost of doctor visits: $21.00												

Table 2 Cost to the Commonwealth of the Influenza Vaccination Program for Older Australians

	Cost																	
	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m	$m.	$m.	$m.	$m.
Coverage rates																		
70%	17.394			17.394			17.394			17.394			17.394			17.394		
75%		18.636			18.636			18.636			18.636			18.636			18.636	
80%			19.879			19.879			19.879			19.879			19.879			19.879
Wastage/leakage																		
10%	2.484	2.484	2.484							2.484	2.484	2.484						
15%				3.727	3.727	3.727							3.727	3.727	3.727			
20%							4.97	4.97	4.97							4.97	4.97	4.97
No. of doctor visits																		
0.5										16.91	18.119	19.327	16.91	18.119	19.327	16.91	18.119	19.327
1	33.821	36.237	38.653	33.821	36.237	38.653	33.821	36.237	38.653									
1.5																		
Total	53.699	57.357	61.016	54.942	58.6	62.259	56.185	59.843	63.502	36.788	39.239	41.69	38.031	40.482	42.933	39.274	41.725	44.176
Assumptions:																		
Non Aboriginal and Torres Strait Islander populatio over 65 years: 2,300,776																		
Cost of vaccine per dose: $10.80																		
Cost of doctor visits: $21.00																		

Table 4 Cost to the Commonwealth of the Pharmacy Guild proposal to distribute Influenza vaccine

	Cost											
	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.	$m.
Coverage rates												
70%	21.597			21.597			21.597					
75%		23.14			23.14			23.14				
80%			24.683			24.683			24.683			
										21.597		
											23.14	
Wastage/leakage												24.583
10%				3.085	3.085	3.085						
15%							4.628	4.628	4.628			
20%										6.171	6.171	6.171
No. of doctor visits												
0.5	16.91	18.119	19.327	16.91	18.119	19.327	16.91	18.119	19.327	16.91	18.119	19.327
1												
1.5												
Total	38.507	41.259	44.01	41.592	44.344	47.095	43.135	45.887	48.638	44.678	47.43	50.181

Assumptions:

Non Aboriginal and Torres Strait Islander population over 65 years: 2,300,776

Cost of vaccine per dose: $13.41

Cost of doctor visits: $21.00

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000058

OUTCOME 1:POPULATION HEALTH AND SAFETY

Topic: CHILDHOOD PNEUMOCOCCAL VACCINATION PROGRAM

Hansard Page: CA 96

Senator Gibbs asked:

[In relation to the Pneumococcal program] I notice in the PBS re talking about children with particular high risk medical conditions. What sort of medical conditions are we talking about?

Answer:

The high risk medical conditions are:

- impaired immune response (haemoglobinopathies, congenital immune deficiency, asplenia, HIV infection, relapsing or persistent nephrotic syndrome), and

- anatomical abnormalities (congenital cyanotic heart disease or a cerebrospinal fluid leak)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000059

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL TOBACCO CAMPAIGN

Hansard Page: CA 99-100

Senator Crowley asked:

If one state produces a really excellent tobacco advertising campaign, does either the Commonwealth or other states pick up on this? Can you give us examples of that? I just wondered whether there were any examples of the Commonwealth's responsibility for a national impact assisting the creative ideas of one state to be known by other states and used in other places. If you can find any examples of that on notice, I would appreciate that.

Answer:

While developing national Drug Offensive materials in 1986-87, the Commonwealth conducted a national media buy using a television commercial ('Bag the fag') that was developed and produced in Queensland.

The National Tobacco Campaign, which launched in 1997, is a collaborative effort of the Commonwealth, States and Territories. These parties work together on the development of phases of National Tobacco Campaign activity, and there has been a pooling of expertise and resources through this process. States and Territories also undertake their own local level campaigns from time to time and sometimes use advertisements produced by other States and Territories. In the normal course of the collaborative approach of National Tobacco Campaign, the Commonwealth, States and Territories share information about their respective campaign activities.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000060

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL TOBACCO CAMPAIGN

Hansard Page: CA101

Senator West asked:

What countries have taken the [Australia's Tobacco Advertising] campaign from us?
Answer:

The following countries have sought to use National Tobacco Campaign materials: USA; Canada; Singapore; Philippines; New Zealand; Cambodia; Mongolia; Italy; United Kingdom; Norway; Poland; Finland; Holland; Iceland; Germany; Armenia; Belarus; Bosnia and Herzegovina; Croatia; Greece; Kazakhstan; Kyrgyzstan; Malta; Republic of Srpska; Russian Federation; Tajikistan; and Tonga. East Timor has also sought application to use the materials, but we understand local infrastructure issues may delay their use of the materials. Representatives from Venezuela and Japan have applied to use creative materials for educational purposes in universities and schools.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000061

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CERVICAL SCREENING PROGRAM

Hansard Page: CA 104

Senator Crowley asked:

[Regarding the cost effectiveness study of the National Cervical Screening Program referred to in the PBS item 6, page 79] Is that the proposal to extend it [cervical screening] beyond two years for all age groups?

Answer:

In the interests of ensuring that the National Cervical Screening Program continues to promote the most appropriate policy, a cost effectiveness study is currently being undertaken by the Centre for Health Economics Research and Evaluation.

The study aims to compare the current strategy of two-yearly screening for women between the ages of 20 and 69 with alternative strategies of annual, three-yearly and five-yearly screening for women 25 to 64, 25 to 69 and 25 to 74.

The National Advisory Committee to the National Cervical Screening Program will consider the outcomes of the final report of the cost-effectiveness study in late 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000062

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CERVICAL SCREENING PROGRAM

Hansard Page: CA 105

Senator Knowles asked:

What is the [National Cervical] screening program expected to achieve? Can you just go through what the outcomes are meant to be?

Answer:

The aims and objectives of the National Cervical Screening Program are set out below.

Overarching Goal

To achieve optimal reductions in the incidence of, and morbidity and mortality attributable to, cervical cancer at an acceptable cost to the community.

Aims

1. To maximise the detection of precursors of cervical cancer within the target population by achieving high participation rates and standards across the screening pathway.
2. To encourage the development of services that are acceptable, appropriate and accessible to the target population.
3. To promote access to information about cervical screening and follow-up services.
4. To promote quality management and high standards of service delivery throughout the screening pathway.
5. To ensure accountability and appropriate monitoring and evaluation of the program at all levels.

Objectives

1. To develop and implement recruitment strategies for unscreened and underscreened women in the target population.
2. To develop and maintain systems to ensure that women with screen detected abnormalities are appropriately followed up.
3. To review regularly the nationally agreed screening policy and strategies to ensure compliance with that policy.
4. To ensure that screening services are available to women with special needs, including Aboriginal and Torres Strait Islander women, women from non-English speakingbackgrounds, and women living in rural and remote areas, and that those services are consistent with their respective needs.

5. To ensure that women and service providers receive comprehensive and accurate information on the benefits and limitations of cervical screening and on the implications and management of screen detected abnormalities.
6. To maintain an effective and nationally consistent Program through Commonwealth leadership, collaboration with the States and Territories, and consultation with professional and consumer groups.
7. To collect and analyse data sufficient to monitor the implementation of the Program, to evaluate its effectiveness and efficiency, and to provide the basis for future policy and Program development decisions.

The performance of the Program is measured against 10 statistical indicators. National and State and Territory data against these indicators are reported annually. The indicators are:

1. Participation
2. Early rescreening
3. Low-grade abnormality detection
4. High-grade abnormality detection
5. Incidence of micro-invasive cervical cancer
6. Incidence of invasive squamous, adenocarcinoma, adeno-squamous and other cervical cancer
7. Mortality
8. Incidence by location
9. Mortality by location
10. Indigenous mortality

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000063

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CERVICAL SCREENING PROGRAM

Hansard Page: CA 106

Senator Crowley asked:

How much [funding is available in the budget measure] for training GPs [under the cervical screening education campaign]?

Answer:

The Government recognises educating General Practitioners regarding cervical screening is an important issue. However, the budget has only recently been announced, and the amount of funding available for this part of the new budget item has not yet been finalised, and will be reported once this occurs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000065

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CERVICAL SCREENING PROGRAM

Hansard Page: CA 109

Senator Crowley asked:

Can you tell us which are those pockets [where access to cervical screening services is a problem]?

Answer:

The Rural Women's GP Service aims to improve access to primary and secondary health services for women in rural Australia who currently have little or no access to a female general practitioner. The Service will deliver female general practitioner services, including cervical screening, to rural communities and larger remote centres.

Attached is a current list of sites which will receive these services (see attachment A).

Question: E01000065
Attachment A

RURAL WOMEN'S GP SERVICE: CLINIC LOCATION BY RFDS SECTION
(as at 31 March 2001)

QUEENSLAND SECTION	CENTRAL SECTION	WESTERN OPERATIONS	SOUTH EASTEN SECTION
Bamaga	Alyangula	Boddington	Corryong
Injinoo	Coober Pedy	Corrigin	Lightning Ridge
New Mapoon	Cummins	Halls Creek	Ouyen
Seisia	Lameroo	Kojonup	Orbost
Umagico	Pinnaroo	Pingelly	Rainbow
Kowanyama	Tennant Creek	Quairanding	Yarram
Lockhart River	Tumby Bay	Wagin	
Aurukun	Woomera	Leonora	
Pormpuraaw	Yorketown	Newman	
Croydon			
Georgetown			
Coen			
Chillagoe			
Mornington Island			
Karumba			
Normanton			
Hughenden			
Bowen			
Julia Creek			
Cloncurry			
Camooweal			
Boulia			
Birdsville			
Jundah			
Bedourie			
Windorah			
Winton			
Biloela			
Sapphire			
Moranbah			
Blackwater			
Moura			
Taroom			
Augathella			
Texas			
Inglewood			

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000144

OUTCOME 2: ACCESS TO MEDICARE

Topic: National Cervical Screening Program

Hansard Page: CA 109

Senator Crowley asked:

The breakdown on how many of these [cervical] screens are done by women doctors as apart from male GPs?

Answer:

A review of Health Insurance Commission data for the financial year 2000-2001 showed that, screening where the gender of the referring medical practitioner was known, 66.5 percent of referrals for cervical cancer were from women doctors.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000071

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: COST RECOVERY

Hansard Page: CA111

Senator Forshaw asked:

Details of amounts recovered where the application confers an exclusive commercial capital benefit to the applicant?

Answer:

To date ANZFA has received a total of $64,000 AUD. This sum relates to four cost recovery applications that are currently being assessed by the Authority.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000066

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN & NEW ZEALAND FOOD REGULATION MINISTERIAL COUNCIL

Hansard Page: CA 112

Senator Forshaw asked:

Can you tell us who will be sitting on the new ministerial council [the Australian and New Zealand Food Regulation Ministerial Council] and the portfolios that they represent for each of the states and New Zealand?

Answer:

The Ministerial Council is chaired by The Honourable Dr Michael Wooldridge, Minister for Health and Aged Care.

Jurisdiction	Minister
Commonwealth	Hon Dr Michael Wooldridge MP (Chair) Minister for Health and Aged Care
	Hon Warren Truss MP Minister for Agriculture, Fisheries and Forestry
	Hon Senator Grant Tambling Parliamentary Secretary, Health and Aged Care
NSW	Lead Minister: Hon Craig Knowles, MP Minister for Health
	Hon Richard Amery, MP Minister for Agriculture
VIC	Lead Minister: The Hon John Thwaites MP Minister for Health
	The Hon Keith Hamilton Minister for Agriculture
	Hon John Brumby Minister for State and Regional Development
	Hon Marsha Thomson Minister for Consumer Affairs and Minister for Small Business
QLD	Lead Minister: The Honourable Wendy Edmond MP Minister for Health
	The Honourable Henry Palaszcuk MP Minister for Primary Industries and Rural Communities
SA	Lead Minister: The Hon Dean Brown MP Minister for Human Services
	The Hon Rob Kerin MP Minister for Primary Industries and Resources
WA	Lead Minister: The Hon Bob Kucera, MLA Minister for Health
	The Hon Kim Chance Minister for Agriculture, Forestry and Fisheries

TAS	Lead Minister: The Hon Judy Jackson MHA Health and Human Services Minister
	The Hon David Llewellyn Minister for Primary Industries, Water and Environment
	The Hon Dr Peter Patmore Attorney-General and Minister for Justice and Industrial Relations
NT	Lead Minister: The Hon Stephen Dunham MLA Minister for Health, Family and Children's Services
	The Hon Mick Palmer MLA Minister for Primary Industries and Fisheries
ACT	Mr Michael Moore MLA Minister for Health, Housing and Community Care
NEW ZEALAND	The Hon Annette King Minister of Health

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question:E01000072

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: BREASTFEEDING/WHO STANDARDS

Hansard Page: CA115

Senator West asked:

Are they [APMAIF] monitoring it [WHO Code]?

Answer:

The Advisory Panel on the Marketing in Australia of Infant Formula (APMAIF) was established by the Commonwealth Government to monitor compliance with and advise the Government on the Marketing in Australian of Infant Formulas: Manufacturers and Importers (MAIF) Agreement. The MAIF Agreement is a self-regulatory arrangement established to address those sections of the WHO Code which aim to prevent the promotion and marketing of infant formula in inappropriate ways.

In 1999-2000 APMAIF received 26 complaints, of which seven were found to be breaches.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000143

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: BREASTFEEDING/WHO STANDARDS

Hansard Page: CA115

Senator West asked:

(a) Can the department tell me if we are upholding and complying with all WHO standards on breastfeeding?

(b) Has there been a change in the WHO Code of late? Has the recommendation changed from four months of breastfeeding to six months of breastfeeding?

Answer:

(a) The World Health Organization's *International Code of Marketing of Breast Milk Substitutes* (WHO Code) aims to protect the nutritional wellbeing of all infants through two separate, but closely related issues: the protection and promotion of breastfeeding, and by ensuring the appropriate use of breast milk substitutes, on the basis of adequate information and through appropriate marketing and distribution.

The WHO Code was adopted in 1981 by the World Health Assembly as a recommendation for member countries to take action appropriate to their social, legal and developmental situations.

The Australian Government implemented the WHO Code applying to the marketing of infant formula through an agreement authorised by the Australian Competition and Consumer Commission under the *Trade Practices Act*. The member companies of the Infant Formula Manufacturers Association of Australia and other manufacturers and distributors have concurred in the setting-up of *the Marketing in Australia of Infant Formula: Manufacturers and Importers Agreement* (MAIF Agreement) and have voluntarily submitted to its constraints in the interest of the health and development of infant in Australia.

It is a self-regulatory arrangement concerned with limiting the promotion and marketing of infant formula and provides for the establishment of the Advisory Panel on the Marketing in Australian of Infant Formula (APMAIF) to monitor breaches of the Agreement.

The Government is also promoting breastfeeding as a public health nutrition issue. This is also consistent with the WHO Code. The National Breastfeeding Strategy funded the development and dissemination of a number of education, training and practice guidelines targeting mothers, lactation consultants and other health professionals. The Government is also providing ongoing support to the Nursing Mothers Association of Australia. Several projects targeting high need communities and focusing on the promotion of breastfeeding have been funded under the National Child Nutrition Program. The Government will continue to consider proposals for projects which aim to increase the rates of breastfeeding in Australia.

(b) The 54th World Health Assembly met in May 2001. It was decided to recommend the adoption of the resolution entitled "Infant and young child nutrition". It urged Member States to support:

" exclusive breastfeeding for six months as a global public health recommendation taking into account the findings of the WHO Expert Technical Consultation on optimal duration of exclusive breastfeeding, the provision of safe and appropriate complementary foods, with continued breastfeeding for up to two years or beyond…."

[Reference: *Agenda Item 13.1, Infant and Young child nutrition, A54/45)* in para. 3(3)]

Australia supported this resolution at the WHO Assembly in May noting that the recommendation of exclusive breastfeeding for six months was relevant for populations generally but noted that this is best implemented when the nutrition and support of the pregnant and lactating mother is favourable, and that for some infants, complementary and/or alternative feeding after four months may be required.

Australia also noted that care must be taken in applying the six-month recommendation in at-risk subgroups of the population (for example those susceptible to potential risks such as iron deficiency anaemia) and in such situations noted the importance of the health professional in assessing and supporting needs on an individual basis.

The Government also supports the individual choice of some mothers who may be unable to, or choose not to, follow this recommendation, ie to use infant formula as an alternative.

The Government is currently funding the NHMRC to undertake a review of its national recommendations on infant feeding which will take into account the new WHO recommendation in the Australian context.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000067

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: GENE TECHNOLOGY ACT

Hansard Page: CA 119-122

Senator Crowley asked:

(a) Which departments are the New South Wales cabinet office consulting regarding the Inter-Governmental agreement on gene technology? (CA119)

(b) Provide a list of state and territories officers that make up the consultative senior officials group? (CA119)

(c) What date in early May was the Inter-Governmental agreement sent to New South Wales? (CA120)

(d) Can you tell me why the power to advise the IBC if special precautionary measures are required in relation to particular low risk dealings is not required under the new Gene Technology Act? (CA122)

Answer:

(a) The Commonwealth is unable to answer matters related to the States on their behalf.

(b) The Commonwealth-State Consultative Group on Gene Technology comprises representatives from all States, Territories and the Commonwealth. Current positions represented on the Committee are detailed in the attachment.

When the Ministerial Council is established under the *Gene Technology Act 2000*, the membership of the consultative senior officials group will reflect Ministerial membership.

(c) The Inter-Governmental Agreement was signed by the Prime Minister 29 April 2001 and sent to New South Wales on 1 May 2001.

(d) The list of notifiable low risk dealings (NLRDs) contained in the Regulations has been based on the Genetic Manipulation Advisory Committee (GMAC) Category B dealings. However a number of important modifications and clarifications have been made:

- The list of NLRDs have been limited and are more restrictive than GMAC's Category B activities.

  For example, "all work involving the production of modified GM plants" was previously Category B. In the past this gave rise to GMAC requiring some additional precautionary measures to ensure that pollen and seed from the plants could not escape. The equivalent NLRD class is now a lot more limited and additional measures **must** be taken if the work does involve plants being grown to flowering stage in order to ensure no escape of GM pollen or seed.

  In addition to the list of NLRDs being more limited (and subject to mandatory additional precautionary measures being applied), a second part has also been included which provides that even if Part 1 of Schedule 3 of the Regulations provides that certain dealings with Genetically Modified Organisms (GMOs) are NLRDs, the work **will not** be an NLRD if it also falls within Part 2 of Schedule 3.

  The effect of this is that any higher risk dealings with GMOs are not NLRDs and must be licensed. This list has been prepared erring very much on the side of caution and in particular many of the activities that used to be NLRD (and subject to special precautionary measures imposed by GMAC) have been placed on the list of activities that are not NLRDs and must be licensed. While this does not necessarily mean that such activities are higher risk, it adopts a cautious approach by ensuring that the Regulator can make a case by case assessment and can apply tailored conditions if this is necessary.

- Additional conditions have been prescribed that must be complied with by all people undertaking NLRDs. In summary, the proposed Regulations provide that notifiable low risk dealings must:

  - be conducted within a contained facility certified to at least PC2 and of appropriate design for containing the type of GMO proposed (or otherwise certified by the Regulator as being suitable for containing the particular GMO); and
  - be properly supervised (for example by the accredited organisation within which the work is conducted) and a record of the details of the dealings retained; and
  - only be transported in accordance with guidelines issued by the Regulator; and
  - if the dealing involves organisms that may produce disease in humans, be conducted in accordance with vaccination requirements set out in the Australian Standard AS/NZA2243:3:1995 (Safety in laboratories: microbiology).

One of the most important changes that has been made to the conditions is that the work must be undertaken in a PC2 facility or *must be undertaken in a facility otherwise specified by the Regulator as providing appropriate containment for the particular GMO*. This change has been made following the most recent round of consultations on the Regulations and a detailed examination of the GMAC files relating to Category B work.

It ensures that the Regulator does have the capacity to tailor the containment requirements if this is necessary because the work is not suited to containment in a standard PC2 facility. For example, if a person proposes to undertake NLRDs with animals, a standard PC2 animal house may not be an appropriate design for the particular animals. As such, the Regulator can go out and inspect alternative facilities (for example, double fenced pens) and if the Regulator is satisfied that the alternative arrangements are appropriate to contain the animals, the Regulator will certify the alternative facility and the work may proceed within that facility, subject to any conditions of certification imposed by the Regulator.

The effect of these modifications has been to limit the class of GMOs that are NLRDs and to enable the Regulator to certify alternative containment facilities, if these are more appropriate to contain the particular GMO. These changes address the concerns raised during consultations on the regulations in relation to ensuring that appropriate precautions are in place in relation to NLRDs.

It should also be noted that there will be ongoing review of the class of NLRDs. The Act provides that the Regulator may at any time review whether a dealing should be a NLRD or whether an existing NLRD should no longer be a NLRD.

Commonwealth-States Consultative Group
June 2001

Note: * indicates core member from the jurisdiction

State or Territory	Position	Department
ACT	Assistant Secretary Chemicals & the Environment Protection Branch	Environment Australia
ACT	Legislative Officer Environment Planning & Legislation	Environment ACT Department of Urban Services
ACT	Director Biotechnology & Biologicals Section	Environment Australia
ACT	Senior Policy Officer Health Protection Service	ACT Department of Health, Housing & Community Care
ACT	Coordinator CSIRO Biotechnology Strategy Unit	CSIRO
ACT	Policy Officer, Projects Section Biotechnology Australia	Department of Industry, Science and Resources
ACT	Manager Projects Section Biotechnology Australia	Department of Industry, Science & Resources
ACT	National Manager TGA	Department of Health & Aged Care
ACT	Biotechnology & Biologicals Section	Environment Australia
ACT	Office of NHMRC	Department of Health & Aged Care
ACT	Executive Officer Agricultural Branch Trade Negotiations Division	Department of Foreign Affairs and Trade
ACT	Assistant Manager Projects Group Biotechnology Australia	Department of Industry Science & Resources
ACT	Assistant Secretary Biotechnology and R&D Policy Branch	AFFA
ACT	Manager Policy Group	ACT Chief Minister's Department
NSW*	Principal Policy Officer Natural Resources Branch	The Cabinet Office NSW Government
NT*	Assistant Secretary Business & Strategic Services	Department of Primary Industry & Fisheries
NT	Policy Officer Policy and Coordination Unit	Department of the Chief Minister
QLD*	Manager Biotechnology Regulation	Department of Premier and Cabinet
QLD	Principal Policy Officer	Queensland Department of Primary Industries

QLD	Manager Environmental Health Unit	Queensland Health
QLD	Principal Policy Officer Biotechnology Regulation Economic Policy, Policy Division	Department of Premier and Cabinet - Queensland
SA*	Senior Scientific Officer Genetically Modified Food Unit Environmental Health Branch	South Australian Department of Human Services
SA	Principal Policy Officer Urban & Resources Policy GP	Department of the Premier and Cabinet
SA	Solicitor	Crown Solicitor's Office
TAS*	Policy Analyst Gene Technology Unit Food Quality & Safety Branch	Department of Primary Industries, Water & Environment
TAS	Director Food Quality & Safety Food Agriculture & Fisheries Division	Dept of Primary Industries, Water & Environment
VIC*	Senior Policy Adviser Resources and Infrastructure	Department of Premier and Cabinet – Victoria
VIC		Department of Health Services
VIC	Director Resources and Infrastructure Branch Cabinet Office	Department of Premier and Cabinet
VIC	Assistant Director Resources & Infrastructure	Department of Premier and Cabinet
VIC	Senior Adviser Government Branch	Department of Premier and Cabinet
WA*	Manager Policy and Planning	Agriculture Western Australia
WA	Manager Policy and Planning	Agriculture Western Australia
WA	Executive Director Science and Technology	Department of Commerce and Trade

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000126

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: STAFFING

Written Question on Notice

Senator Forshaw asked:

(a) How many people are currently employed by ARPANSA?

(b) How many people are employed in respect of each of the functions or activities carried out by ARPANSA as outlined on page 268 of the 2001-02 PBS? (Alternatively how is ARPANSA structured in order to carry out its various functions and how many staff are engaged in each areas?)

(c) How many current or former staff of ARPANSA have previously been employed by ANSTO?

(d) On page 65 of the PBS one of the activities listed includes "Maintaining world class expertise in the science of radiation protection and nuclear safety."

(e) How is this objective achieved? How many staff with such world class expertise does ARPANSA employ?

(f) The table on Pg. 62 of the PBS states that ARPANSA's average staff level will remain the same in 2001-2002 as it is for 2000-01. Will ARPANSA engage any additional staff in the coming year to deal with ARPANSA's application for a construction licence?

(g) Has ARPANSA engaged any consultants since it was established? If so, why? Please provide details including the name of the consultant, the purpose and the cost.

(h) Does ARPANSA intend to engage any consultants in 2001-02. If so, why?

Answer:

(a) ARPANSA currently employs 128 staff as at 15 June 2001.

(b) ARPANSA is made up of the Office of the CEO (3 staff), the Standards, Policy and Corporate Support Branch (47 staff), the Regulatory Branch (20 staff), the Medical Radiation Branch (14), the Non-Ionising Radiation health Branch and the Environmental and Radiation Health Branch. A copy of the organisational structure is located on the world wide web at http://www.arpansa.gov.au/org.htm#es.

(c) ARPANSA currently employs 10 former staff of ANSTO and previously employed 1 former staff member of ANSTO.

(d) No answer required.

(e) This objective is achieved by ARPANSA staff attending and participating in international and local conferences, seminars, working groups, technical groups, inspections, workshops, committees, peer reviews and similar programs and activities. In the past financial year staff have on approximately 90 occasions either attended or participated in conferences, seminars workings groups, technical groups, inspections, workshops, committees, peer reviews and similar programs and activities or published technical or scientific reports or news sheets. This figure is indicative of the number of persons ARPANSA employs with world class expertise.

(f) No.

(g) Consultants engaged by ARPANSA since it was established are as follows:

Name of consultant	**Purpose**	**Cost**
1998/1999 (Feb 1999 - Jun 1999)		
BR Lawrance Consulting	Safey Assessment of Nuclear Facilties(formulation of principles and criteria	10,460
Matthews Peggs Consulting	Legal Services	62,624
Amaroo Associates Pty Ltd	Accounting Services	50,129
Paxus People	IT systems including Y2K	18,400
Dr I A Mumme	Geology, Siesmicity & Hydrology Aspects - Research Reactor Siting Application	1,830
Martin Cocker	Accounting/Costing Services	6,000
1999/2000		
Acumen	Corporate Administration	4,512
Jelmett Pty Ltd	VMS Consultancy	720
Hayes Associates	Administration Review	14,950
Amaroo Associates Pty Ltd	Accounting Services and GST	54,656
Cocker and Associates	Activity Based Costing	31,831
Dr I A Mumme	Seismically Matters in Sydney Basin	1,830
BR Lawrence Consulting	Technical assessment and preparation of regulation guidelines	31,499
Paxus People	IT Strategic Plan and administration staffing review	101,200
Media Monitors	Media Monitoring Services	12,612
Matthew Pegg Consulting	Legal Services	18,190
Minter Ellison	Legal Advice	25,292
Anderson's Legal	Legal Advice on GST implementation	21,612
	Quality Assurance Accreditation Project	19,200

Name of consultant	Purpose	Cost
2000/2001		
Ivan Albert Mumme	Services in relation to Geologic & Seismic assessment	3,000
Palm Management	Lyn Stadtmiller - 2 day project management workshop	5,046
Angles & Angels	Business Analyst consulting	10,738
Seismology Research Centre	Extension of Seismic study for Lucas Heights	6,000
Russell J Cuthbertson	Extension of Seismic study for Lucas Heights	5,671
EME Australia	ARPANSA EME Standard working group	2,800
ITIM Australia	David Peake On site assistance services	368
NIR Services	Assessment of ARPANSA licence applications	3,014
IOCOM Solutions	Supply of technical services	732
Fittings Plus	RF Working Group evaluation Rev & Practice	3,250
Liebert Corporation	Computer contract	28,000
L F Carmody	General Management	1,050
B R Lawrence Consulting	Safety Assessment Principles	1,167
David Black	RF Working Group	14,828
SL Engineering	Provision of expert advice on nuclear safety and related matters by S Kidziak	2,500
Australian Government Solictors	ARPANSA Consultancy Agreement	5,077
Amaroo Associates	Reporting/Budgeting	55,767
SL Engineering	Advice on documentation & safety of nuclear plant	5,000
Wyndarra Consulting	Risk Management	18,523
NMIT	Faye Bellis Quality system development	29,040
Professor Mark Elwood	Rev & Best practice evaluation	12,208
Bruce Hocking & Associates	Sitting fee & preparation of drafts	5,600
EnviroRad Services	M B Cooper Consultancy Services	6,270
Wordsworth	Technical Editing Services	3,040
William Buck Consulting	IT Infrastructure Review & Development of Request for tender for replacement FMIS	58,200

(h) At this point in time potential candidates for consultancies in 2001/2002 are:

CITEC	IT Market Testing Scoping Study
Seismology Research Centre	Seismic studies
BR Lawrance Consulting	Safety Assessment
Australian Government Solictors	Legal Advice
Amaroo Associates	Accounting Services
Wyndarra Consulting	Internal Audit

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000127

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: BUDGET

Written Question on Notice

Senator Forshaw asked:

(a) Pg. 62 of the PBS notes that ARPANSA's budget is expected to increase from $15,803,00 in 2000-01 to $18,216,00 in 2001-02. What is the reason for the increase?

(b) Pg. 62 of the PBS notes that ARPANSA received $6,887,000 revenue from "other sources" in 2000-01 and this expected to increase to $7,643,000 next year in 2001-2002. What are those "other sources" of revenue?

(c) Pg. 269 of the PBS lists ARPANSA's expenses. What is the reason for the expected increase in expenses for "suppliers" from $6,555,000 in $2000-01 to $8,183,000 in 2001-02?

(d) Pg. 271 of the PBS details ARPANSA's "Investment Activities". It notes that "purchase of property, plant and equipment…" is expected to rise from $530,000 in 2000-01 to $859,000 in 2001-02 and then fall back to $630,000 in 2002-03. Why is this?

Answer:

(a) ARPANSA's budget has increased in 2001/2002 as a result of changes to ARPANSA's supplementation for ComCover and capital use charge, and an expected increased in the level of revenue from regulation licence fees.

(b) "Other Sources" of revenue are as follows: (i) sale of goods and services, (ii) regulation licence fees and (iii) interest. The expected increase in "other sources" revenue takes into account an expected rise in regulation licence fees in 2001/2002.

(c) Suppliers expenses will increase in 2001/2002 as a result of the Comcover premium payment of $1.6M.

(d) The variation between financial years in the cash flow statement's investing activities relates to the building and physical security upgrade and improvement to meet PSM standards, as well as IT network and network security purchases.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000128

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NEW REACTOR – LICENCE APPLICATION

Written Question on Notice

Senator Forshaw asked:

(a) ANSTO recently lodged an application for a licence to construct the new reactor at Lucas Heights. Would you please outline the process involved and the timeframe for consideration of the application?

(b) Will you adopt the recommendations of the recent Senate Selection Committee's report, which relate to ARPANSA's consideration of the application? If no, why not?

(c) Will ARPANSA employ any additional staff or any consultants to assess the application?

(d) How does ARPANSA intend to provide for community consultation and participation in the process.

(e) What experience does ARPANSA staff have in granting licenses for nuclear reactors?

(f) What are the particular areas that ARPANSA has to look at when considering the granting of a license to construct?

(g) What impact will the fact that a site for the waste store has not yet been identified, or that the search for such a site has not yet started, have on the process to approve the reactor license?

(h) What impact will the uncertainty over the reprocessing arrangements for spent fuel have on the process to approve the reactor license

Answer:

(a) Please see attached preliminary schedule for review of Australian Nucellar Science Technology Organisation (ANSTO) Replacement Research Reactor Project licence application.

(b) The following recommendation that appears on page 228 of the Senate Select Committee's report relate to ARPANSA's consideration of the application to construct a research reactor:

"The Committee recommends that, if the new research reactor project is to go ahead, the Government put in place a number of mechanisms to ensure that full and thorough public scrutiny of the proposal takes place during the licensing process. This is to ensure, to the greatest extent practicable, that the construction and operation of the proposed reactor would not adversely affect the health of the community or damage the environment. At a minimum, these mechanisms must include:

- publication of all submissions made to ARPANSA during the licensing process [Recommendation 1];
- publication of ARPANSA's responses to concerns raised in these submissions, detailing in what way those concerns have affected the CEO's decision [Recommendation 2];
- release of the full details of the design and the construction contract except for those items which are determined as truly commercial-in-confidence [Recommendation 3]."

The ARPANSA licensing process already addresses Recommendations 1 and 2. Upon receipt of an application for a licence to undertake conduct in relation to a nuclear facility, a Safety Evaluation Report (SER) is prepared by staff of ARPANSA's Regulatory Branch. The SER documents the review of the application (against the criteria in the *Australian Radiation Protection and Nuclear Safety Regulations* 1999 and ARPANSA's Regulatory Assessment Principles), draws conclusions as to acceptability of application and makes recommendations to the CEO of ARPANSA as to whether or not a licence should be issued along with conditions of licence. The SER identifies the persons who have made public submissions and summarises the issues they have raised. The SER is made available to the public at the time of the licensing decision in hardcopy and on the agency's website.

ARPANSA is unable to adopt Recommendation 3 of the Report in relation to the contract to construct the proposed replacement research reactor.

(c) ARPANSA does not expect to employ any additional staff to assess the application. ARPANSA has or will engage consultants in the areas of seismic design, safe structure, systems and components and for the peer review of the PSAR. Additional consultancies in other areas of expertise may be engaged as the review proceeds.

(d) The *Australian Radiation and Nuclear Safety Regulations* 1999 require the CEO of ARPANSA to advertise receipt of all applications for facility licences in a national daily newspaper and the Government gazette. Where the application relates to a nuclear installation, the CEO of ARPANSA must also invite submissions and take into account any submissions received on the application when making a decision on whether to issue a facility licence.

In the case of the application for facility licence to construct the Replacement Research Reactor, the CEO advertised receipt of the application and invited submissions in advertisements in the Gazette, the Australian, the Sydney Morning Herald and the St George and Sutherland Shire Leader. A media conference was also held on 5 June 2001 to announce the invitation of submissions and publicise the locations of copies of the application and the submission process. Reference copies of the full application, including the full Preliminary Safety Analysis Report (PSAR), were sent to public libraries in Sutherland, Engadine and Menai, the National Library, the NSW State Library and its counterparts around Australia, and are available for reading at ARPANSA's Miranda and Yallambie offices. Copies were also sent to environmental and community organisations interested in the replacement reactor proposal, and to the

Councils of Sutherland Shire and Liverpool City. A summary of the PSAR, together with the formal application, and a guide to lodging submissions were made available to the public free on request on a CD and as a paper copy, and these documents are also available on the ARPANSA internet site.

ARPANSA recently leased an additional office in Miranda that includes a Public Resource Room where all the information on the application and the public consultation process can be accessed by the public. The resource room was primarily established to provide the public with convenient access to information on the replacement reactor application.

The first round of public submissions will end on 5 September 2001. Before then, the report of the International Peer Review of the PSAR and written questions on the application by ARPANSA staff and ANSTO's replies will also be available and made public by ARPANSA. It is intended that the first round of submissions will identify the main issues on which the public would like more information. By October 2001, issues papers will be prepared by ARPANSA on the main issues to emerge from the first round of public submissions, the Peer Review report and the questions and answers on the application. A second round of submissions will be invited on these issues papers, to end in by December 2001. The CEO will take into account all public submissions when considering his decision on the application.

A public information session was held in Engadine on 14 June 2001, at which ARPANSA staff provided information and answered questions from the public on the application and PSAR, the regulatory assessment process and criteria for the application, and the public information and submission process. The CEO also answered questions from the public on these and other issues. Another public information session is planned for August or September 2001, to provide information on the second round of submissions.

(e) ARPANSA staff possess the following experience: granting of authorisation of operation of HIFAR research reactor and decommissioning of MOATA research reactor. Additionally, senior scientists and engineers in ARPANSA have been involved with licensing of power and research reactors within the United States and United Kingdom.

(f) ARPANSA will review the application for a licence to construct the reactor against the requirements of the *ARPANS Regulations* and the agency's Regulatory Assessment Principles and Design Criteria (that set out international best practice for nuclear installations). Particular areas of consideration arising in relation to the application include:

(i) international best practice;
(ii) design of the reactor;
(iii) analysis of the full spectrum of accidents to the reactor. (This will include the Reference Accident used to assess site suitability to see whether the assumptions made at the siting application bound the design described in the construction application.);
(iv) seismic design; and
(v) spent fuel and wastes.

(g) The CEO of ARPANSA has offered a general opinion on the management of the spent fuel, the establishment of the store for long-lived intermediate-level waste (ILW) and the replacement research reactor project, and it has been conveyed to officers of the relevant Government Departments and to ANSTO. The CEO's opinion is that:

- at the time of a decision on a licence to **construct** the replacement reactor:
  (1) arrangements for the reprocessing of the specific fuel proposed for use in the reactor would need to be demonstrated to be available when the reactor would be in operation; and
  (2) there would need to be progress on the strategy to establish a store for ILW, including for the waste arising from the reprocessing of spent fuel;
- at the time of a decision on the licensing of the **operation** of the replacement reactor (it is expected that this licence would be sought in 2005):
  (1) the arrangements for reprocessing of its spent fuel would need to be entirely firm; and
  (2) with regard to the ILW store, there would need to be substantial and evident progress - such as the features of the design settled, siting criteria established and a strategy and timetable in place for a site (s) – that it was moving forward with clear paths to its future establishment and the CEO could be satisfied that a store will exist.

It is recognised that there is significant room for judgement in the scope of this opinion at both licensing stages. The CEO intends to make final decisions when an application has been received and the relevant information and public submissions are to hand.

(h) It is understood that the French Government has indicated its support for COGEMA and stated the Government's willingness to ensure that any difficulties in honouring the contract are overcome. It appears that this mean that the French Government will take steps to overcome any legal impediments, should they be found, to the execution of the COGEMA contract.

There is also no doubt that Australia needs a long-term store for long lived waste such as the product from reprocessing the HIFAR spent fuel. While the planned future operations of the reactor add somewhat to the quantity of spent fuel, they neither overwhelm nor negate the existing need for a long-term solution. The CEO of ARPANSA is satisfied that Government resolve to achieve resolution – through sending US obligated fuel to the US for final disposal and reprocessing the remainder, with radioactive wastes returned to Australia for long-term storage - provides reasonable assurance that the existing and future spent fuel from HIFAR operations will be dealt with properly. Continued progress towards establishing a store is vital.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000129

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: LOW LEVEL WASTE REPOSITORY

Written Question on Notice

Senator Forshaw asked:

(a) Pg. 268 of the PBS says that ARPANSA will assess licence applications for the national low level waste repository.

(b) Have you received an application yet? If an application has been lodged please provide details and a copy.

(c) How long will it take to assess an application for a licence to construct the low level repository?

(d) What arrangements will be made to provide community consultation in the process dealing with a licence for the low level repository?

(e) What are the areas of assessment that ARPANSA has to specifically look at when considering the granting of a license?

Answer:

(a) No answer required.

(b) No.

(c) Depending on the form of the application, up to a period of 9 months.

(d) The *Australian Radiation and Nuclear Safety Regulations* 1999 require the CEO of ARPANSA to advertise receipt of all applications for facility licences in a national daily newspaper and the Government gazette. Where the application relates to a nuclear installation, the CEO of ARPANSA must also invite submissions and take into account any submissions received on the application when making a decision on whether to issue a facility licence.

It is envisaged that a similar public submission and information process will be put in place for any application for a licence for the proposed low level radioactive waste repository. Details of that process will be developed as more information on any application becomes available.

(e) An application would need to be assessed against the criteria in the ARPANSA Regulations and the agency's Regulatory Assessment Principles. It is expected that the following types of issues would be considered in the assessment process: suitability of the site, geological and hydrological conditions, impact of external events (including human made and seismic), meteorology, demography and acceptance and conditioning criteria for waste proposed to be stored at the repository.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000130

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: PUBLIC CONSULTATION

Written Question on Notice

Senator Forshaw asked:

Pg. 268 of the PBS says that ARPANSA is responsible for "implementing a process for public consultation and participation in the licensing…" of the new reactor and waste repository.

(a) What does this involve precisely?

(b) How do you intend to consult with the public on these matters?

(c) How much money is spent on these consultation strategies?

(d) How many staff are employed in this task?

(e) Do you envisage holding public forums?

(f) Are any of ARPANSA'S consultation strategies outsourced? If so, which ones?

Answer:

(a) The *Australian Radiation and Nuclear Safety Regulations* 1999 require the CEO of ARPANSA to advertise receipt of all applications for facility licences in a national daily newspaper and the Government gazette. Where the application relates to a nuclear installation, the CEO of ARPANSA must also invite submissions and take into account any submissions received on the application when making a decision on whether to issue a facility licence.

In the case of the application for facility licence to construct the Replacement Research Reactor, the CEO advertised receipt of the application and invited submissions in advertisements in the Gazette, the Australian, the Sydney Morning Herald and the St George and Sutherland Shire Leader. A media conference was also held on 5 June 2001 to announce the invitation of submissions and publicise the locations of copies of the application and the submission process. Reference copies of the full application, including the full Preliminary Safety Analysis Report (PSAR), were sent to public libraries in Sutherland, Engadine and Menai, the National Library, the NSW State Library and its counterparts around Australia, and are available for reading at ARPANSA's Miranda and Yallambie offices. Copies were also sent to environmental and community organisations interested in the replacement reactor proposal, and to the

Councils of Sutherland Shire and Liverpool City. A summary of the PSAR, together with the formal application, and a guide to lodging submissions were made available to the public free on request on a CD and as a paper copy, and these documents are also available on the ARPANSA internet site.

ARPANSA recently leased an additional office in Miranda that includes a Public Resource Room where all the information on the application and the public consultation process can be accessed by the public. The resource room was primarily established to provide the public with convenient access to information on the replacement reactor application.

The first round of public submissions will end on 5 September 2001. Before then, the report of the International Peer Review of the PSAR and written questions on the application by ARPANSA staff and ANSTO's replies will also be available and made public by ARPANSA. It is intended that the first round of submissions will identify the main issues on which the public would like more information. By October 2001, issues papers will be prepared by ARPANSA on the main issues to emerge from the first round of public submissions, the Peer Review report and the questions and answers on the application. A second round of submissions will be invited on these issues papers, to end in by December 2001. The CEO will take into account all public submissions when considering his decision on the application.

A public information session was held in Engadine on 14 June 2001, at which ARPANSA staff provided information and answered questions from the public on the application and PSAR, the regulatory assessment process and criteria for the application, and the public information and submission process. The CEO also answered questions from the public on these and other issues. Another public information session is planned for August or September 2001, to provide information on the second round of submissions.

It is envisaged that a similar public submission and information process will be put in place for any application for a licence for the proposed low level radioactive waste repository. Details of that process will be developed as more information on any application becomes available.

(b) Please refer to answer (a).

(c) For the replacement reactor application, it is expected that money spent on the consultation process described above will be at least $50,000, being printing and copying of materials, hire of equipment and personnel costs for public meetings and advertising.

It is expected that costs of public consultation for any application for the proposed waste repository would of the order of $15,000.

(d) For the replacement reactor application, 17 staff plus the CEO are employed in the above process, to varying extent.

It is expected that the number of staff involved in public consultation for any application for the proposed waste repository would be about 12.

(e) The public information sessions described include discussions between members of the public and ARPANSA staff and the CEO. The CEO has said that he is considering convening some form of public hearing on the replacement reactor application at which other parties such as ANSTO could discuss the application with ARPANSA and the public.

(f) None of ARPANSA's consultation strategies are outsourced.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000131

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CODES OF PRACTICE

Written Question on Notice

Senator Forshaw asked:

Pg. 268 of the PBS notes that an additional function of ARPANSA is to "…develop national codes of practice, including a standard for radio frequency radiation…"

(a) Could you please explain what this involves?

(b) How do you go about developing these codes of practice and standards?

(c) How many staff are involved in this function?

(d) At what cost would ARPANSA fulfil this role?

(e) Do you consult with the public in meeting this objective?

Answer:

(a) Section 15 (1) (a) of *Australian Radiation Protection and Nuclear Safety Act* 1998 specifies a function of the CEO of ARPANSA "to promote uniformity of radiation protection and nuclear safety practices across jurisdictions of the Commonwealth, the States and the Territories". The Act also establishes the Radiation Health and Safety Advisory Council, the Radiation Health Committee and the Nuclear Safety Committee. In particular, the Radiation Health Committee functions are:

"(1) The Radiation Health Committee has the following functions:
- (a) to advise the CEO and the Council on matters relating to radiation protection;
- (b) to develop policies and to prepare draft publications for the promotion of uniform national standards of radiation protection;
- (c) to formulate draft national policies, codes and standards in relation to radiation protection for consideration by the Commonwealth, the States and the Territories;
- (d) from time to time, to review national policies, codes and standards in relation to radiation protection to ensure that they continue to substantially reflect world best practice;
- (e) to consult publicly in the development and review of policies, codes and standards in relation to radiation protection."

In undertaking its functions, the Radiation Health Committee is reviewing the 34 current publications in the former Radiation Health Series of NHMRC. NHMRC has passed responsibility for this series to ARPANSA. The 3 Codes published under the now repealed Environment Protection (Nuclear Codes) Act 1978 are also being reviewed. Several other areas where new guidance is needed have been identified by the Radiation Health Committee, including the development of the radiofrequency standard.

Publications developed by ARPANSA through the Radiation Health Committee will form part of a new Radiation Protection Series comprising Radiation Protection Standards, Codes of Practice, Safety Guides, and Recommendations.

Publications developed by the Radiation Health Committee provide nationally agreed guidance that will also be adopted by State and Territory radiation protection regulators, and form the basis of promoting a uniform approach to radiation protection throughout Australia.

(b) The process used by Radiation Health Committee is to appoint a working group including relevant expertise and interests to prepare a draft for the committee to review. Working Group members are drawn from ARPANSA, State and Territory radiation protection regulators, industry, interest groups, and the community. The Committee provides a document development plan, which sets out advice to the working group on the material to be included in the publication and a proposed timetable. The Committee regularly reviews working group progress. When a draft is sufficiently developed, a period of public comment is held to obtain feedback on the draft. The working group will then review the comment and provide the Committee with a revised draft and a report on its review of public comment.

The development of Codes and Standards must also meet the COAG *Principles and Guidelines for National Standard Setting and Regulatory Action by Ministerial Councils and Standard-Setting Bodies* (Nov 1997). Hence, a regulatory impact statement must be prepared on each proposed publication.

As part of the process for national uniformity, the codes and standards will then be submitted to the Australian Health Ministers Advisory Council (AHMAC) and the Australian Health Ministers Conference (AHMC) for adoption into the National Directory for Radiation Protection, which is currently being prepared by the Radiation Health Committee.

(c) The ARPANSA secretariat, which supports the operation of the Radiation Health and Safety Advisory Council, the Radiation Health Committee, and the Nuclear Safety Committee, including assisting in the development of codes of practice and standards, consists of six staff. It is estimated that they spend approximately 50% of their time dealing with Radiation Health Committee business related to development of codes and standards. Other ARPANSA staff are appointed to working groups on subjects where they have relevant expertise. Other working group members are drawn from the State and Territory radiation protection regulators, relevant industry and interest groups, who nominate people with expertise on the issues under consideration.

(d) The cost of supporting the Radiation Health Committee in developing Codes of Practice and Standards over the past two financial years is estimated to be $750,000. This includes the cost of committee meetings, working group meetings, 50% of secretariat salary costs, and an estimate of the salary costs of other ARPANSA staff involved in working groups.

(e) Yes. The Radiation Health Committee's functions as detailed above include a requirement to consult publicly in the development and review of policies, codes and standards in relation to radiation protection. For example, the draft Code of Practice on the Safe Transport of Radioactive Material was released for public comment from 28 April until 28 May 2001, and the draft radiofrequency standard was released from 5 March until 11 May 2001. The COAG Principles and Guidelines for national standard setting also include a consultation requirement.

The Radiation Health Committee also includes a person to represent the interests of the general public, as do relevant working groups.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000132

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: INSPECTIONS

Written Question on Notice

Senator Forshaw asked:

Pg. 77 of the PBS notes that ARPANSA will "…conduct 40 inspections of Commonwealth radiation sources and facilities and nuclear installations…" over the next year.

(a) What are these?
(b) When will they take place?
(c) What does this involve?
(d) How many staff are involved?
(e) Are these findings/reports made available to the public? If not, why not?

Answer:

(a) Inspections, visits and audits are undertake for purposes including provision and gathering of information about licence applications; gaining an understanding of the licence holders operating processes; witnessing tests of plant and equipment operation; auditing licence holders' operating procedures and specific technical aspects important to safety management; auditing compliance with *the Australian Radiation Protection and Nuclear Safety Act* 1998 and Regulations and licence conditions; and investigating accidents and incidents on matters the subject of the Act..

(b) It is not possible to provide details of particular inspections. Inspections will occur during the course of the next year.

(c) Briefly, an inspection involves authorised persons or inspectors appointed by the CEO under the ARPANSA Act: (i) identifying the need for and purpose of the inspection; (ii) establishing the criteria for the inspection; (iii) undertaking the inspection (including discussions with staff of the licence holder and inspecting the site, plant and equipment); and (iv) preparation of an inspection report for the CEO of ARPANSA.

(d) Up to 15 staff of ARPANSA's Regulatory Branch, with different types of expertise, undertake inspections, audit and visits. Other scientific staff from ARPANSA also participate depending on required expertise.

(e) The inspections, audits and visits are reported in the quarterly and annual reports, where necessary.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000133

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: PAPERS & REPORTS

Written Question on Notice

Senator Forshaw asked:

Pg. 78 of the PBS says that ARPANSA will publish "…at least 15 scientific papers, technical reports and issues reports…"

(a) Who are these aimed at?

(b) Who are these produced for?

(c) Where are they made available?

(d) On what topics are these produced? Do you have a publications plan?

(e) How many staff are dedicated to this task?

(f) How many were published in 2000-01.

Answer:

(a) A wide range of stakeholders. Scientific papers are published in the refereed scientific literature with the purpose to disseminate the results of ARPANSA's scientific work to the national and international scientific community. These papers add to the world corpus of knowledge on radiation protection and nuclear safety. Technical reports generally deal with specific scientific or technical issues, including the results of surveys of medical and other radiation doses, environmental or other measurements, quality assurance programs and descriptions of ARPANSA facilities or methodologies. These reports are generally aimed at other national and international practitioners or persons concerned with radiation protection and nuclear safety. Issue reports are generally aimed at specific topics or issues, e.g. Maralinga does assessments, uniformity, or to provide guidelines on specific radiation protection issues.

(b) These publications are produced for a wide range of stakeholders, including the scientific community, the radiation protection community and medical users of radiation.

(c) Scientific papers are available in journals held by libraries or other institutions. Technical reports are ARPANSA publications available on request from ARPANSA. A number of publications are available on the ARPANSA Web site.

(d) On a wide range of topics related to radiation protection and nuclear safety, and on medical exposures to radiation. ARPANSA has a draft publications policy which it intends to finalise shortly. A publications plan is being developed.

(e) Generally, staff are not specifically dedicated to the task of preparing publications. Publications are part of their overall scientific and technical work.

(f) ARPANSA published 39 scientific, technical and issues reports.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000134

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: ADVICE ON RADIATION PROTECTION AND NUCLEAR SAFETY

Written Question on Notice

Senator Forshaw asked:

Pg. 268 of the PBS says that ARPANSA will "…provide advice…" on radiation protection and nuclear safety.

(a) Is this advice to the Department and/or the Minister?

(b) What form does this advice take? Papers or verbal briefings, or both?

(c) How many pieces of advice did you provide in 2000-01?

(d) Is this advice publicly available?

(e) How regularly is ARPANSA called on to fulfil this function?

Answer:

(a) ARPANSA provides advice to Environment Australia, Australian Customs Service, the Department of Health and Aged Care, Departmental committees (in particular to the Therapeutic Goods Administration), the medical profession, professional bodies and to the public.

(b) Advice is provided both in writing and verbally.

(c) The agency provides advice on a daily basis. At this time, it is still developing a system to record the number of advices provided.

(d) Unless the advice is intended for public consumption (for example information sheets and telephone advice), it is not usually made publicly available.

(e) As and when required.

ADRAC UPDATE ON BUPROPION (ZYBAN SR)

Bupropion (Zyban SR) was first marketed in Australia late in 2000 as a short-term aid to giving up smoking and has had very high usage. It was initially developed as an antidepressant. It is a selective inhibitor of the neuronal re-uptake of catecholamines in the brain but its mechanism to enhance the ability to quit smoking is unknown.

The assessment of reactions to bupropion use is difficult because many patients experience the effects of nicotine withdrawal in addition to the effects of bupropion. Since November 2000 the Adverse Drug Reactions Advisory Committee (ADRAC) has received 780 Australian reports of suspected adverse reactions in connection with the use of Zyban SR. In 758 of these, Zyban SR was implicated as the sole suspected drug. The more commonly reported problems involved skin reactions (307 reports), psychological disturbances (285), the nervous system (268), and the gastrointestinal tract (172) as indicated in the table below.

Table: More Commonly Reported Reactions with Bupropion

Adverse Reaction	No of Reports
Skin	
Urticaria	167
Other rashes	86
Other itch	46
Neurological	
Dizziness/ataxia	78
Headache	68
Tremor	57
Convulsions/twitching	48
Paraesthesia/hypoaesthesia	40
Psychiatric	
Insomnia	78
Agitation	58
Anxiety	50
Depression	45
Gastrointestinal	
Nausea	87
Vomiting	30
Other	
Facial/angioedema	62
Chest pain	54
Shortness of breath	38
Increased sweating	33
Serum sickness	33

The profile of the drug is dominated by hypersensitivity reactions and neurological and psychiatric effects.

The majority of hypersensitivity reactions involve relatively minor skin reactions but there have also been reports of facial oedema or angioedema and serum sickness-like reactions. The latter describe a syndrome of a skin rash or urticaria with joint pain or swelling. The delayed onset ranging from 5 to 37 days (median: 17 days) after commencement of bupropion is also consistent with a serum sickness-like syndrome. In at least 16 of the cases, steroids were given.

Bupropion can cause seizures and is contraindicated in patients with epilepsy. It should be used with great caution in those with a predisposition to seizures including those abusing alcohol or taking another medication that can lower the seizure threshold. This includes most antidepressant and antipsychotic drugs, insulin, oral hypoglycaemic drugs and anorectic products.

Care also needs to be taken in prescribing bupropion for patients with a history of psychiatric conditions, and especially those taking drug therapy, because of the possibilities of interactions or additive effects. These are identified in the product information.

Recent media coverage has highlighted a small number of Australian reports to ADRAC of suspected adverse reactions to bupropion where the patient died. To date, there have been nine such reports in patients aged from 30 to 61 years of age. There has not been a single dominant mode of death.

The death of a patient may be caused by a drug or may be coincidental. Smokers are at increased risk of cardiovascular death and early symptoms of cardiovascular disease may have prompted therapy with bupropion. As with all reports with fatal outcomes, ADRAC seeks detailed follow-up information including post-mortem and coronial reports to aid its assessments of the individual cases.

ADRAC is satisfied, to date, that bupropion has not emerged as a cause of unexpected deaths. ADRAC meets every six to seven weeks and is keeping the drug's safety under close review.

Produced by Therapeutic Goods Administration, 14 May 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000021

OUTCOME 2: ACCESS TO MEDICARE

Topic: NORMISON REVIEW

Hansard Page: CA 91

Senator Denman asked:

How is the review into Normison going?

Answer:

NORMISON is a brand name of temazepam, a prescription drug belonging to the benzodiazepine class of hypnotics, or sleeping agents. There are four other brands of this medicine available on the Australian market. Temazepam is a useful agent in the short-term management of insomnia in adults.

Unfortunately, this medicine is misused by a small group of drug dependent users, who inject temazepam, and others in the benzodiazepine class, to augment the effect of heroin, or as a substitute for heroin when they cannot afford or obtain heroin.

To assist in addressing the problem of prescription medicine abuse, the National Drug Strategic Framework has established a committee under the auspices of the Australian Pharmaceutical Advisory Council (APAC) to advise the Government on ways to reduce the intentional misuse of pharmaceuticals (IMP committee).

While there is no formal review of NORMISON per se, the IMP committee recently considered issues in relation to reducing the misuse by injecting drug users of temazepam, and other benzodiazepine drugs.

The IMP committee noted a lack of substantial evidence available on the extent and adverse effects of the intentional misuse by injection of benzodiazepines, particularly temazepam capsules. As a step in building an evidence base, recent research on the trends in benzodiazepine injection in the Victorian and Tasmanian jurisdictions will be completed shortly.

The committee had also recommended that consideration be given to reformulating temazepam capsules to make them less hazardous on injection. Issues raised during initial discussions include disappointing results following comparable action in the United Kingdom, and the potential significant cost impost on both consumers and industry.

The committee also believes that positive change in this area can result from addressing the high levels of benzodiazepine prescribing in Australia. Planning has begun on a demonstration project to examine appropriate interventions and supporting materials for prescribers and those working in the field of prescription drug abuse.

In addition, the successful 'doctor shopping' intervention program, coordinated by the Health Insurance Commission, has identified individuals obtaining multiple prescriptions for substances of potential abuse, including NORMISON. Counselling, education and information strategies are directed at both medical practitioners and doctor shoppers themselves, resulting in significant reduction in doctor shopping behaviour.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000022

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS ESTIMATES

Hansard Page: CA129/130

Senator Evans asked:

(a) And then, in last year's Budget I think the original estimate was that we would spend $3.795 billion. Is that right?

(b) What did you revise it to in the midyear review?

Answer:

(a) Yes.

(b) At the time of the mid year review (January 2001), the estimate of Pharmaceutical Benefits Scheme (PBS) expenses for 2000-01 was revised to $4.141 billion.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000025

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS EXPENDITURE GROWTH

Hansard Page: CA133

Senator Evans asked:

Provide more details of factors contributing to growth in PBS expenditure.
[Provide a detailed breakdown on the increase in the PBS expenditure.]

Answer:

Pharmaceutical Benefits Scheme (PBS) expenses totalled $3.499 billion in 1999-00 and are expected to total around $4.190 billion in 2000-01, an increase of $691 million or 19.7 per cent.

There are two main identifiable drivers of growth in PBS expenses - increases in the average cost to Government of PBS prescriptions, and increases in prescription volumes. The average cost to government of PBS prescriptions is expected to increase from $23.08 in 1999-00 to $25.83 in 2000-01 and PBS prescription volumes to grow by 7.9 per cent. Overall, it is estimated that in 2000-01, around $415 million of PBS growth is related to increases in the average cost to government of PBS prescriptions and $276 million to volume growth.

In terms of individual drugs and drug groups, the major factors are:
- listing of new medicines for treating arthritis and nicotine dependence;
- increase in expenditure on cholesterol lowering medicines; and
- growth in drug groups such as chemotherapy drugs; medicines for the treatment of depression and psychoses; medicines for the treatment of asthma; drugs for the treatment of hypertension; and drugs for the management of stroke patients.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000026

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS VOLUME GROWTH

Hansard Page: CA133

Senator Evans asked:

Do you have figures on the volume growth for the last year or so?

Answer:

The growth in PBS prescription volumes over the last three years has been as follows:

Year	Number of Scripts	%
1998-99	128,921,168	3.04
1999-00	138,081,550	7.11
2000-01	136,497,432	(actual for July to May)
	149,076,796	7.96 (estimated for 12 months)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000043

OUTCOME 2: ACCESS TO MEDICARE
Topic: RESEARCH BY DR KEVIN WHITE

Written Question on Notice

Senator Carr asked:

(a) Has the Department's attention been drawn to an article in the 30 March 2001 edition of the ANU Reporter identifying research undertaken by Dr Kevin White dealing with the degree to which the Medicare system in Australia is being rorted through large-scale buy-outs of general practices by overseas corporations, leading to the health care system becoming a profit source for American investors with consequent dangers to the level of health care?

(b) What is the Department's response to this research?

(c) What action is being taken to ensure that the conditions allowing such problems to occur are corrected?

Answers:

(a) The Department is aware of Dr White's research.

(b) The Department has been advised that a report of Dr White's research has not yet been released publicly. The Department will make an appropriate response once the report becomes available.

(c) On 19 June 2001 in Canberra, the Minister for Health and Aged Care, Dr Wooldridge, met with representatives of the five major corporations involved in the provision of medical services (Foundation HealthCare, Endeavour HealthCare, Mayne, Medical Care Services and Primary Health Care), the RACGP and the AMA. The meeting initiated the process of developing a comprehensive code of conduct for medical corporations to protect doctors' clinical independence and autonomy and maintain high quality services for patients.

The Health Insurance Commission (HIC) routinely monitors providers as part of its risk management of Government programs, and in particular with respect to fraudulent and inappropriate behaviour. The HIC has recently commenced work on a data analysis with regard to providers who are associated with corporations involved in the provision of medical services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000023

OUTCOME 2: ACCESS TO MEDICARE

Topic: ZYBAN PRESCRIPTIONS

Hansard Page: CA132

Senator Evans asked:

Provide the month by month figures on the prescriptions of Zyban

Answer:

The month by month figures available to date in 2001 on prescriptions of Zyban are:

Month	Scripts	Gov't Cost
		$
February	20,122	4,894,653
March	93,231	22,605,964
April	51,538	12,492,707
May	71,433	17,034,092
Total	236,324	57,027,416

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000024

OUTCOME 2: ACCESS TO MEDICARE

Topic: COST OF STATINS

Hansard Page: CA133

Senator Evans asked:

Provide financial year figures for growth in the cost of Statins.

Answer:

The growth in the cost to Government of PBS prescriptions for the statin (cholesterol lowering) group of drugs over the last three years has been as follows:

Year	Gov't Cost	Growth	
	$	%	
1998-99	363,354,083	32.7	
1999-00	473,677,001	30.4	
2000-01	522,835,634		(actual for July to May)
	574,776,592	21.3	(estimated for 12 months)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000027

OUTCOME 2: ACCESS TO MEDICARE

Topic: LETTER TO BMJ ON LIPID LOWERING DRUG USAGE PATTERNS

Hansard Page: CA 136

Senator Gibbs asked:

Could the Committee have a copy of this?

Answer:

Yes. A copy of the letter is at Attachment A.

Extract sourced from http://www.bmj.com/cgi/content/full/321/7268/1084#Fu1

BMJ 2000;321:1084 (28 October)

Letters

Discontinuation rates for use of statins are high

EDITOR - Packham et al describe an almost fourfold increase in the use of statins between 1996 and 1998.[1] The rationale for this treatment is well established,[2] yet drug discontinuation rates are generally far lower in controlled trials than in routine care.[3] We have conducted an Australia-wide assessment of discontinuation rates in patients newly prescribed lipid lowering drugs.

Using national prescription records, we identified 420 543 patients prescribed a lipid lowering drug in Australia in April 1999; this represented 68% of all lipid lowering drugs dispensed nationally in this month. We extracted records on 32 384 patients who had not received such a drug in the preceding three months. Continuation of treatment was assessed from pharmacist payment claims for the period November 1999 to January 2000 inclusive, representing 6-7 months of treatment with some time allowed for late dispensing of prescriptions.

Altogether 9% of patients (2740) were aged below 50, 47% (15 141) were 50-69, and 44% (14 222) were 70; 52% (17 069) were women; 66% (21 006) were resident in an Australian capital city. The table shows dispensing data at least six months after initial supply.

Around 92% of drugs used were statins. Discontinuation rates averaged 30% and were broadly similar with all statin drugs. Discontinuation rates were higher in those younger than the median age of 68 (32% (2457/7706) v 26% (1845/7189) in men, 33% (2947/8879) v 29% (2357/8190) in women). In multiple logistic regression the significant predictors of discontinuation were age (relative risk 0.97 for each year of increasing age; 95% confidence interval 0.97 to 0.98) and not living in a capital city (0.87; 0.82 to 0.92

Dispensing data six to seven months after initial supply. Figures are numbers (percentages)

Drug dispensed	Patients who started drug	Patients who continued	Patients who switched drugs drug	Patients who stopped taking drug for lipid lowering
Simvastatin	12 554	8 246 (66)	818 (6)	3490 (28)
Atorvastatin	11 034	6 864 (62)	810 (8)	3360 (30)
Pravastatin	4 776	2 917 (61)	528 (11)	1331 (28)
Fluvastatin	759	411 (54)	119 (16)	229 (30)
Cerivastatin	626	323 (52)	103 (16)	200 (32)
Gemfibrozil	1 808	941 (52)	294 (16)	573 (32)
Resin	424	139 (33)	62 (12)	223 (53)
Nicotinic acid	383	102 (27)	30 (7)	251 (66)
Probucol	20	8 (40)	7 (35)	5 (25)
All lipid lowering drugs	32 384	19 951(62)	2 771 (9)	9 662 (30)

Statins are a class of drugs with a low rate of adverse events and good cholesterol lowering efficacy. Hence there are likely to be other explanations for a 30% discontinuation rate. These high discontinuation rates represent a considerable wastage of resources and a lost opportunity for proved prevention of heart disease.

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John Dudley, *analyst programmer*.
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Competing interests: None declared. Funding: No external funding.

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1. Packham C, Pearson J, Robinson J, Gray D. Use of statins in general practices, 1996-8: cross sectional study. BMJ 2000; 320: 1583-1584[Full Text]. (10 June.)
2. Gould AL, Rossouw JE, Santanello NC, Heyse JF, Furberg CD. Cholesterol reduction yields clinical benefit: impact of statin trials. Circulation 1998; 97: 946-952[Abstract/Full Text].
3. Simons LA, Levis G, Simons J. Apparent discontinuation rates in patients prescribed lipid-lowering drugs. Med J Aust 1996; 164: 208-211[Medline].

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000028

OUTCOME 2: ACCESS TO MEDICARE

Topic: REPORT ON LIPID LOWERING DRUG USAGE PATTERNS

Hansard Page: CA137

Senator Evans asked:

(a) What we would like is a copy of their report, I suppose, simply put.

(b) Did they provide a copy of the report to the PBAC?

Answer:

(a) A copy of the report presented at the June 2000 meeting of the Drug Utilisation Sub-Committee (DUSC) of the Pharmaceutical Benefits Advisory Committee (PBAC) is at Attachment A and a copy of the report presented at the September 2000 meeting of the PBAC is at Attachment B.

(b) Yes, in the form at Attachment B.

Extract from Drug Utilisation Sub-Committee (DUSC) Agenda – June 2000

Length of lipid lowering drug therapy

Earlier published work (MJA 1996; 164: 208-211) using a prospective survey of 12 month's dispensing data in 138 community pharmacies across metropolitan Sydney had found that around 60% of patients apparently discontinued their lipid-lowering medication over 12 months.

To assess length of therapy within the HIC claims database the DUSC secretariat conducted a patient tracking study that followed a group of `new users' of lipid lowering drugs.

A cohort of new users in the month of April 1999 was assembled (defined by no dispensing of a lipid-lowering drug script in the previous three months). This cohort was examined for any record of the supply of lipid lowering drugs within the three-month period November 1999 to January 2000 i.e. a period at least six months after initial supply. Note was also taken of any switching between hypolipidaemic drugs.

For all `new users' (32,384 PINS) of a lipid lowering drug in April 1999, 9,662 (29.8%) had no record of a hypolipidaemic drug dispensed in a period at least six months later. The same period in the earlier work indicated around 50% discontinuation.

Initial drug	Taking same drug	Taking another drug	No record of lipid lowering drug
Simvastatin	65.7%	6.5%	27.8%
(12, 554)	(8, 246)	(818)	(3, 490)
Pravastatin	61.1%	11.05%	27.9%
(4, 776)	(2, 917)	(528)	(1, 331)
Atorvastatin	62.2%	7.3%	30.5%
(11, 034)	(6, 864)	(810)	(3, 360)
Cerivastatin	51.6%	16.5%	31.95%
(626)	(323)	(103)	(200)
Fluvastatin	54.15%	15.7%	30.2%
(759)	(411)	(119)	(229)
Gemfibrozil	52.05%	16.3%	31.7%
(1,808)	(941)	(294)	(573)
Resin binders	32.8%	14.6%	52.6%
(424)	(139)	(62)	(223)
Nicotinic acid	26.6%	7.8%	65.5%
(383)	(102)	(30)	(251)
Probucol	*40%*	35%	25%
(2 0)	(8)	(7)	(5)

Extract from Pharmaceutical Benefits Advisory Committee (PBAC) Agenda – September 2000

Length of therapy

Earlier published work (MJA 1996; 164: 208-211) using a prospective survey of 12 month's dispensing data in 138 community pharmacies across metropolitan Sydney had found that around 60% of patients apparently discontinued their medication over 12 months.

To **assess** length of therapy within the HIC claims database the DUSC secretariat conducted a patient tracking study that followed a group of `new users' of lipid lowering drugs.

A cohort of new users in the month of April 1999 was assembled (defined by no dispensing of a lipid-lowering drug script within the previous three months). *This* cohort was examined for any record of the supply of lipid lowering drugs within a follow-up three-month period at least six months after the initial supply (November 1999 to January 2000). Note was also taken of any switching between hypolipidaemic drugs.

For all `new users' (32,384 PINs) of a lipid lowering drug in April 1999, 9,662 (29.8%) had no record of a hypolipidaernic drug dispensed in a period at least six months later. The same period in the earlier work indicated around 50% discontinuation within this time period (although it had counted all patients who moved away from the survey pharmacies as discontinuations). The resin binders and nicotinic acid had the lowest percentage of patients still taking the same therapy at least six months after the initial supply.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000029

OUTCOME 2: ACCESS TO MEDICARE

Topic: CORRESPONDENCE FROM APMA TO MINISTER ON STATINS
Hansard Page: CA 140

Senator Gibbs asked:

Is the Department aware of correspondence sent by the APMA to the Minister in response to the Budget measure? Is a copy of the letter available?

Answer:

Yes, the Department is aware of the correspondence.

A copy of the letter is not available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question:E01000030

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICARE EXPENDITURE ON OBSTETRIC ULTRASOUND

Hansard Page: CA 147

Senator Harradine asked:

How much is spent from Medicare on [obstetric] ultrasound services?

Answer:

Medicare benefits for obstetric ultrasound services totalled $37,765,000 in 1999/2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question:E01000032

OUTCOME: 2: ACCESS TO MEDICARE

Topic: MEDICARE CLAIMS FOR THIRD TRIMESTER TERMINATIONS

Hansard Page: CA 151

Senator Harradine asked:

(a) Do you have any there, for which Medicare has been claimed, for over 28 weeks?

(b) So these would be mainly performed in hospitals?

Answer:

(a) Medicare benefit is not payable for third trimester termination of pregnancy.

(b) Accordingly, there is no Medicare data available on whether such services would be performed in hospital.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000033

OUTCOME: 2 ACCESS TO MEDICARE

Topic: BABY J CASE WITHIN CATEGORIES UNDER 16525

Hansard Page: CA 151

Senator Harradine asked:

(a) Did the Baby J case come within any of the categories that were mentioned under 16525.

(b) Has the Department given further consideration to the issues that I raised about the matter on the previous occasion.

Answer:

(a) The Department is unaware of the clinical circumstances of the Baby J case beyond that reported in the media and, therefore, cannot advise whether it would be covered by Medicare Benefits Schedule item 16525.

(b) As previously advised, appropriate clinical practice relating to specific medical procedures is a matter for State health authorities and the appropriate professional medical associations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000035 OUTCOME 2: ACCESS TO MEDICA

Topic: ACT COVERING THE PROFESSIONAL SERVICES REVIEW COMMITTEE

Hansard Page: CA 154

Senator Harradine asked:

Where in the Act does it prevent the Professional Services Review Committee from considering the questions that I have asked about late-term abortions and the methods used - whether the methods are appropriate and whether the late-term abortions are clinically relevant services?

Answer:

The Professional Services Review Scheme (PSRS) is authorised under the Health Insurance Act 1973 ('the Act'). The relevant provisions are contained in Part VAA (sections 80 to 106ZR).

The process of professional services review is specified in the Act. That process is primarily concerned with service providers rather than with individual services described in the Medicare Benefits Schedule. Under the legislation, the Health Insurance Commission ('the HIC') may refer to the Director, Professional Services Review, the conduct of a medical practitioner as to whether that person has engaged in inappropriate practice. A practitioner engages in inappropriate practice if the practitioner's conduct, in connection with rendering or initiating services, is such that a Professional Services Review Committee (PSRC) could reasonably conclude that the conduct would be unacceptable to the general body of the practitioner's peers. A PSRC is appointed by the Director, Professional Services Review (DPSR).

The process of professional services review is instigated by a referral from the HIC following its investigation into whether the conduct of a practitioner may constitute inappropriate practice. In relation to the specific questions raised, the Act specifies that a PSRC in the course of the professional review process, following a referral from the HIC, may examine a practitioner's conduct to determine whether a service is clinically relevant ie. in this case, 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.

For late term abortions to be referred to a PSRC, it would be necessary that:

- the HIC formed the view that there were concerns about the conduct of the person who provides services covered by item 16525 (management of second trimester labour, with or without induction, for intrauterine fetal death, gross fetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies);

- the HIC referred the conduct of that person under review to the DPSR, relating to whether the person has engaged in inappropriate practice in connection with rendering the service/s;
- the DPSR formed the view that the person under review may have engaged in inappropriate practice in connection with rendering the service/s;
- the DPSR set up a PSRC and made a referral to that Committee to consider whether the PUR's conduct constituted engaging in inappropriate practice.

It is therefore possible that particular services such as late term abortions could be considered by a PSRC in the context of the referral of the conduct of a particular doctor, but not in general.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000036

OUTCOME: 2 ACCESS TO MEDICARE

Topic: MEDICARE COVER OF IVF TREATMENT CYCLES – INCREASE IN COST OF UNLIMITED IVF TREATMENT CYCLES

Hansard Page: CA 155

Senator Harradine asked:

(a) Has the department any information on costings for the unlimited Medicare covered IVF treatment cycles?

(b) The actual increase in the cost to the taxpayer of this decision and a comparison with figures for limited treatment cycles costs.

Answer:

(a) The Department estimated, prior to implementation, that the lifting of the 6-cycle limit for item 13200 would result in additional Medicare benefits expenditure of approximately $900,000 per year.

(b) As this initiative was introduced on 1 November 2000, at this stage there is insufficient data to establish the actual cost of this decision. The Department will be undertaking a detailed analysis to determine expenditure in respect of treatment cycles beyond 6 once there is 12 months' data available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000037

OUTCOME 2: ACCESS TO MEDICARE

Topic: Expenditure on Better Medication Management System (BMMS)

Hansard Page: CA166

Senator Evans asked:

Could you give me the chart which says, 'This is what we were going to spend and this is what we were going to save under Proposal 1 and this is what we're going to spend and this is what we're going to save under the revised proposal.'

Answer:

Table 1 shows the detail of the Budget 2000 funding for the Better Medication Management System. The figures reported for the Department of Health and Aged Care in the *Portfolio Budget Statements 2000-01* (page 77) are taken from the 'Total Health' line in Table 1.

TABLE 1: INITIAL PROPOSAL - BMMS FUNDING (EXPENSE, $ MILLION)

Item	00-01	01-02	02-03	03-04	04-05
Administered					
PBS	-1.800	-21.460	-45.100	-51.320	-51.320
Pay Pharmacists/doctors	2.200	15.900	22.530	26.010	26.010
Departmental	21.160	21.120	12.872	9.331	10.701
Total Health	21.560	15.650	-9.698	-15.979	-14.609

Note: 04-05 expenses were not published in the Portfolio Budget Statements 2000-01 *but are included for completeness.*

There are four types of adjustments that have been made to BMMS funding since Budget 2000/01.

1. Correction of error

   The figures presented as expenses in the *Portfolio Budget Statements 2000-01* were actually cash figures. Hence, adjustments were made in September 2000 Additional Estimates to include liability (thereby converting to expenses).

2. Delay of BMMS start by one year

Administered expenses, both PBS savings and incentive payments for doctors and pharmacists, were adjusted to reflect an expected start date of 1 July 2002, instead of 1 July 2001 as expected in the original proposal. These adjustments were made in the Budget 2001 process but are not separately reported in the published Budget documentation.

Note that the evidence presented at Senate Estimates hearings provided some of these adjustments. A letter to Senator Knowles (dated 15 June 2001) corrected the statement made during that hearing.

3. Adjustments as a result of overall increases in PBS expenditure

The PBS savings arising from the BMMS are based on total PBS activity. As volume and price increase, the expected savings from BMMS also increase. Thus, the increases to estimated PBS expenses led to consequential increases to the PBS savings component of BMMS expenses.

4. Redirection of some funding to the Improved Monitoring of Entitlements initiative

The Improved Monitoring of Entitlements initiative is an important building block for BMMS development. The Department of Finance and Administration approved a transfer of funds to IME activity from the BMMS because of the synergies between the two initiatives.

Table 2 shows the detail of the current Budgeted funding for BMMS reflecting the combined effect of all these adjustments.

TABLE 2: ESTIMATES OF ALLOCATIONS FOR BMMS (EXPENSE, $ MILLION) (AS AT 22 JUNE 2001)

Item	00-01	01-02	02-03	03-04	04-05
Administered					
PBS	0.017	-2.143	-28.254	-59.962	-71.474
Pay Pharmacists/doctors	0.000	7.115	17.666	24.728	26.704
Departmental	21.160	18.920	12.872	9.331	10.701
Total Health	21.177	23.892	2.284	-25.903	-34.069

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Senator Sue Knowles
Chair
Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2601

Dear Senator

Correction to Budget Estimates Evidence

I am writing to correct misinformation I provided to the Committee at the Budget Estimates 2001-2002 hearings on 29 May 2001.

During the hearings, Senator Evans sought information on the Budget 2001 adjustments (not reported in the *Portfolio Budget Statements 2001-02*) arising from the delayed start of the Better Medication Management System (BMMS).

I advised that the adjustments were as follows:

Year	01-02	02-03	03-04	04-05
$ million	-6.275	-4.864	-1.282	0.694

When providing these figures, I advised that the adjustment is the total of changes to the PBS savings and the expenditure on incentives for doctors and pharmacists. In fact, this adjustment is for the Bill 1 Administered expenses only (that is, the incentive payments) and does not include the adjustment to PBS savings.

This corrected information will also be included in the response to the question taken on notice (Hansard CA165/166 of 29 May 2001) to provide details of funding for the initial proposal and for the proposal following all the adjustments.

Yours sincerely

Jennifer Badham
A/g Assistant Secretary
BMMS Implementation Taskforce
15 June 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000038

OUTCOME 2: ACCESS TO MEDICARE

Topic: RVS COST

Hansard Page: CA 169

Senator West asked:

What is the total cost to the Government of conducting the RVS over the 6 years?

Answer:

The total cost of the RVS to the Government was $7,891,557.

Note: The Relative Value Study: Stage 3 Modelling: a technical report, May 2001 was tabled at the hearing on 29 May 2001.

The report may be accessed at:

http://www.health.gov.au/haf/docs/rvsstage3model.pdf

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000039

OUTCOME 2: ACCESS TO MEDICARE

Topic: NUMBER OF MRI SCANS FUNDED UNDER MEDICARE

Hansard Page: CA 172

Senator Evans asked:

(a) Have you been able to do a breakdown on the number of scans funded for each machine eligible for Medicare?
(b) The spread and the locational issues about whether we are funding the right machines in the right places.

Answer:

(a) Yes. The table below outlines the number of MRI units for which the number of services processed by the Health Insurance Commission fall within certain ranges, for the period 1 September 1998 to 5 June 2001:

Number of services	Number of MRI units
0 – 2,999	9
3,000 – 5,999	21
6,000 – 8,999	23
9,000 – 11,999	10
12,000+	3

This table includes a Western Australian unit that had its eligibility status reinstated, but does not include seventeen other units that became ineligible from 1 November 1999. Nor does the table include an eligible unit in Victoria that has not yet been installed.

(b) The table below outlines the locations of MRI units:

State or Territory	Metropolitan	Regional	Sub-total
New South Wales	15	8[a]	23
Victoria	13[b]	3	16
Queensland	6	5	11
Western Australia	6[c]	0	6
South Australia	5	0	5
Tasmania	2	1	3
ACT	2	0	2
NT	1	0	1
TOTAL	**50**	**17**	**67**

[a] One unit located on the NSW/Victorian border.
[b] Includes an eligible unit in Victoria that has not yet been installed.
[c] Includes the changed eligibility status of a previously ineligible MRI unit.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000044

OUTCOME 2 ACCESS TO MEDICARE

Topic: MRI

Hansard Page: CA173

Senator Evans asked:

In relation to the MRI scanner owned by the Perth Imaging Group,

(a) Could you confirm that Perth Imaging claimed that the machine was a replacement of one already had in place?

(b) And the HIC did not know they had it in place?

(c) What was the status and how did the HIC treat that and why?

(d) Why wasn't it known that the machine was a replacement machine rather that a new machine, two years ago?

(e) When did this machine come to light?

(f) When did the Department make the decision that it was to be treated as an eligible machine?

(g) Why was it so late before new information was received?

(h) When did the HIC take the decision that the machine was not eligible?

(i) In relation to the claims for the services now eligible for benefits (eligible services backdated to 1 November 1999) and which are now being submitted by Perth Imaging for payment, what is the amount of benefit for that period

Answer:

(a) Perth Imaging claimed that the machine was a 'replacement' for a machine ordered prior to 10 February 1998 but which had never been installed.

(b) The HIC was aware, from 5 January 1999, that the 'replacement' machine was in place as claims for Medicare benefits were being made from 5 January 1999.

(c) The 'replacement' machine was initially 'eligible equipment' from 5 January 1999 because it was ordered under an irrevocable contract dated 11 May 1998 and first became operational on 5 January 1999. When the regulations were amended in October 1999 to move the eligibility date for metropolitan machines backwards to 10 February 1998, the HIC determined that this machine no longer satisfied the amended regulations and this 'ineligibility' took effect from 1 November 1999.

(d) The HIC was not advised that the MRI machine in operation at Perth Imaging was considered a 'replacement' machine until October 2000.

(e) The HIC received the first advice from Perth Imaging regarding the installation of this machine in September 1998. This advice was in the form of an application for the eligibility of the machine to be considered by the HIC on the basis of the machine being 'uninstalled as at 12 May 1998 but purchased or leased under a irrevocable contract dated on or before 12 May 1998'.

(f) In February 2001, the HIC received legal advice that the 'replacement' machine satisfied the regulations and could be considered eligible equipment. The HIC advised Perth Imaging that their scanner would be eligible on receipt of the necessary statutory declarations. The statutory declarations were provided and, on 27 March 2001, the HIC informed Perth Imaging that their scanner was eligible equipment.

(g) The HIC was clarifying various facts regarding this matter and liaising with Perth Imaging until January 2001. In addition, legal advice was obtained and considered.

(h) Please see answer to part (c).

(i) The amount of benefit is estimated to be $950,000 to $1,000,000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question:E01000040

OUTCOME 2 – ACCESS TO MEDICARE

Topic: MAGNETIC RESONANCE IMAGING (MRI)

Hansard Page: CA 175-6

Senator Evans asked:

I would like to know what negotiations or contact you had with the South and/or the Bunbury Regional Hospital, and how you characterised those discussions and any understandings reached.

Answer:

Imaging the South responded on 23 December 1999 to a public call for submissions to the Review of MRI, chaired by Professor John Blandford. Imaging the South was sent a copy of the Blandford Report and its executive summary following its release. Neither the Department nor the Review Committee entered into any discussions or further correspondence with Imaging the South in relation to its submission.

Dr Johnny Walker, Clinical Director of Imaging the South, wrote to the Department on the 22 June 2000 in relation to Medicare eligibility for MRI. The Department responded on the 26 July 2000, noting that future arrangements for MRI funding would be determined following the Minister's consideration of the Review.

Dr Walker has written to the Department most recently on 23 May 2001, and has subsequently met with departmental officers (30 May 2001). Dr Walker has also been in telephone contact with officers. These discussions were related to the MRI Request for Tender. In particular, Dr Walker has asked why southwest Western Australia is not an area of need for the purposes of the tender. He also attended the public briefing on the tender process on 1 June 2001. All discussions have been about Government policy. No understandings have been reached.

There have been no negotiations with Imaging the South or the Bunbury Regional Hospital.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000141

OUTCOME 2: ACCESS TO MEDICARE

Topic: REQUEST FOR TENDER DOCUMENT

Hansard Page: CA176

Senator West asked:

Provide a copy of the MRI Request for Tender Document.

Answer:

Please see attached copy of the MRI Request for Tender document and Addendum Number 1 to the Request for Tender.

RFT 157/0001

Request for Tender

Medicare Benefits Scheme: Magnetic Resonance Imaging - Additional Units in Areas of Need

Department of Health and Aged Care

All queries regarding this Request for Tender should be directed to:

Ms Leonie Smith
Contact Officer
MDP 107, Central Office
Department of Health and Aged Care
GPO Box 9848, Canberra ACT 2601
Facsimile (02) 6289 8509
Leonie.Smith@health.gov.au

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000041

OUTCOME: 2 ACCESS TO MEDICARE

Topic: NEGOTIATING IMPLEMENTATION OF INTEGRATED NATIONAL DIABETES PROGRAM 2001/02 BUDGET MEASURE

Hansard Page: CA185

Senator Crowley asked:

Can I know the names of the people who will be involved in the negotiation?

Answer:

The implementation of the Diabetes incentive for GPs announced in the 2001/2 budget will be negotiated through the General Practice Memorandum of Understanding (GP MoU) Group. Membership of the GP MoU Group at present is as follows:

Dr Paul Hemming (Royal Australian College of General Practitioners)
Dr Jenny Williams (Royal Australian College of General Practitioners)
Ms Liz Furler (Royal Australian College of General Practitioners)
Dr David Mildenhall (Rural Doctors Association of Australia)
Dr Geoff White (Rural Doctors' Association of Australia)
Mr Brian Curren (Rural Doctors' Association of Australia)
Dr Julie Thompson (Australian Divisions of General Practice)
Dr Jillian Grogan (Australian Divisions of General Practice)
Dr Stephen Clark (Australian Divisions of General Practice)
Mr Ian McRae (Department of Health and Aged Care)
Mr Andrew Tongue (Department of Health and Aged Care)
Dr Paul Dugdale (Department of Health and Aged Care)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000042

OUTCOME 2: ACCESS TO MEDICARE

Topic: CHECKING DOCTORS COMPLY WITH CRITERIA FOR PIP PAYMENTS FOR DIABETES

Hansard Page: CA 185

Senator Crowley asked:

How are you going to test that doctors are up to scratch and abiding by the criteria?

Answer:

The Practice Incentive Program (PIP) payments for diabetes are still being developed in consultation with the general practice profession, and criteria for receiving payments are yet to be set. Audit processes will be developed when the payment process is finalised.

The PIP is currently audited by the Health Insurance Commission (HIC). The HIC may audit some aspects of the program as part of their existing audit activities.

2001 Aged Care Approvals Round

Release of New Places

Table 1: Places available for allocation in States and Territories in the round

	Residential High Care	Residential Low Care	**Residential Total**	**Community Care**	**Total Places**
NSW	201	1,560	**1,761**	**558**	**2,319**
VIC	621	773	**1,394**	**372**	**1,766**
QLD	469	561	**1,030**	**257**	**1,287**
WA	302	370	**672**	**135**	**807**
SA	227	275	**502**	**134**	**636**
TAS	14	109	**123**	**41**	**164**
ACT	50	20	**70**	**6**	**76**
NT	30	30	**60**	**66**	**126**
• Total places	1,914	3,698	**5,612**	**1,569**	**7,181**

Table 2: Places advertised nationally for allocation in any State and Territory for restructuring and Conversions

	Residential High Care	Residential Low Care	**Residential Total**	**Community Care**	**Total Places**
Restructuring	250	500	**750**	**60**	**810**
Conversions				**400**	**400**
Total National Pool	250	500	**750**	**460**	**1,210**

Table 3: Places released for allocation outside the round

	Residential High Care	Residential Low Care	**Residential Total**	**Community Care**	**Total Places**
MPS	115	110	**225**	**75**	**300**
Emergency care	100	100	**200**		**200**
Innovative	100	100	**200**	**100**	**300**
Sub - Total	315	310	**625**	**175**	**800**
Flexible care*					**350**
Total Pool					**1,150**

MPS and Flexible care places are flexible Subsidy places under the Act

* Flexible care places are available for both residential and community care

TOTAL PLACES FOR ALLOCATION IN 2001 ACAR 9,541

COMMONWEALTH OF AUSTRALIA

Aged and Community Care
GPO Box 9848, Canberra ACT 2601
Telephone: (02) 6213 4827 Fax: (02) 6213 4834
ABN 83 605 426 760

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 Tuesday 20 February 2001, during supplementary Budget Estimates 2000-2001 hearings before the Senate Community 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 the status of Mowbray House which was subject to an exceptional circumstances determination. I indicated that the home had been sold to a new approved provider, that residents were moving to better premises and there were now seven (7) residents remaining at Mowbray House. On reviewing recently the circumstances at each of those homes with an exceptional circumstance determination I have found that this information was incorrect. There is a new provider who has upgraded the premises. However, residents have not been required to move from the site during building renovations.

The error in my answer relating to the number of residents and that they were to move from the site was due to a misinterpretation of my briefing material.

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

Yours sincerely

Jenny Hefford
A/g Assistant Secretary
Complaints and Compliance Taskforce

24 May 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000064

OUTCOME 4: QUALITY HEALTH CARE

Topic: ABORIGINAL INTERPRETER SERVICES

Hansard Page: CA 108

Senator Crowley asked:

Check the number of Aboriginal interpreter services as part of general practice health?

Answer:

The Department does not provide any specific funding for Aboriginal interpreter services as part of general practice health.

However, the Department does fund a General Practice Project Officer to coordinate the development of a network of General Practitioners and other primary health care workers engaged in Aboriginal health. Through these linkages we hope to gain a better knowledge of practices, relationships and resources in the aboriginal health sector and to work with General Practitioners including those in private practice, to achieve optimal approaches to aboriginal health care delivery.

A number of Divisions of General Practice, particularly those in areas with significant indigenous populations undertake activities to improve health outcomes for indigenous people. The provision of interpreter services is not generally amongst these activities.

The Department also funds a large number of Aboriginal community controlled health services that provide primary health care to Indigenous communities. These organisations provide health services that specifically address cultural and language issues and are therefore particularly accessible and responsive to Indigenous clients. A number of Divisions of General Practice and local GPs are effectively working in partnership with Indigenous communities and specific health organisations to improve the quality of local health service delivery.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000073

OUTCOME 4: QUALITY HEALTH CARE

Topic: CALL CENTRE TRIAL

Hansard Page: CA178

Senator Evans asked:

What is the precise date of the closure of the call centre trial?

Answer:

Under the terms of the contract the Perth After Hours Primary Medical Care Trial (AHPMCT) is due to finish on 30 June 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000074

OUTCOME 4: QUALITY HEALTH CARE

Topic: AFTER-HOURS GP SERVICES

Hansard Page: CA180

Senator Evans asked:

Were the existing after-hours general practice services in Perth able to quantify whether the increase in demand was a result of the call centre referring people to them or not?

Answer:

There is anecdotal evidence from the majority of existing after hours practices that they are dealing with increased referrals from the Perth Call Centre, 'Health Direct'. This correlates with the overseas experience of call centres whereby patients who previously would go to an emergency centre or chose sometimes inappropriately, to wait till morning actually took the advice of the Call Centre and went to the local GP after hours service.

The Call Centre has referral data but due to privacy regulations restricting the linkage of the data they have to attendances at after hours services, including emergency departments, they are unable to accurately quantify this.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000075

OUTCOME 4: QUALITY HEALTH CARE

Topic: MENTAL HEALTH RESOURCES

Hansard Page: CA191

Senator Crowley asked:

Can you provide the committee with statistics that back your claim? (that there had not been a loss of mental health resources over the last decade since community care replaced institutional care.)

Answer:

The National Mental Health Report 2000 shows that the commitment made by all State and Territory Governments to protect mental health resources during a period of rapid change was met by all jurisdictions. During the period 1993-1998 (the term of the First National Mental Health Plan) national spending on mental health increased by 30 percent in real terms.

A copy of the report is provided. The report is also located on the Mental Health website http://www.mentalhealth.gov.au/resources/reports/nmhr2000.htm.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000140

OUTCOME 4: QUALITY HEALTH CARE

Topic: LOW PREVALENCE DISORDERS

Hansard Page: CA192

Senator Evans asked:

Can you provide a copy of the report by Professor Assen Jablensky – a study into low prevalence disorders?

Answer:

Copies of the reports:

People Living with Psychotic Illness: An Australian Study 1997-98 An Overview

People Living with Psychotic Illness: An Australian Study 1997-98

are provided.

The reports are also located on the Mental Health website at:
http://www.mentalhealth.gov.au/resources/reports/pdf/overview.pdf
http://www.mentalhealth.gov.au/resources/reports/pdf/psychot.pdf

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000076

OUTCOME 4: QUALITY HEALTH CARE

Topic: MENTAL HEALTH PUBLICATIONS

Hansard Page: CA192

Senator West asked:

What are your printing and publishing costs (for mental health publications) per year and where does the funding come from?

Answer:

Printing and publishing cost vary year to year depending on the timing of release of publications. In the 2000-01 financial year the Mental Health & Special Programs Branch has incurred printing and publishing costs of $530,000 as at 15 June 2001. This included the release of several major publications including the Mental Health Promotion and Prevention Action Plan and Monograph 2000. The publishing and printing of mental health publications is funded from departmental funding.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000077

OUTCOME 4: QUALITY HEALTH CARE

Topic: PRACTICE NURSES

Hansard Page: CA 160

Senator West asked:

I would like the evidence from the UK and New Zealand and I would like to have a look at the projects that the Department has funded that obviously form the basis for this proposal."

Answer:

Evidence from New Zealand and the United Kingdom
Please see table at Attachment A.

Projects funded by the Department.
Please see overview at Attachment B.

Selected References on Practice Nursing

Reference	What they did	What they found	Implications for Australia
Atkin K, (1995)[i] UK	This article draws on material from a national study to explore the role of continuing training and education for different groups within co-located services, including practice nurses, general practitioners, representatives from Family Health Service Authorities (FHSAs), commissioners of community nursing services and managers of community nursing provider units.	Continuing training and education is fundamental to the development of practice nursing. Practice nurses use a variety of education and training opportunities and do not seem particularly disadvantaged in their training pathways. However many feel the informal arrangements covering training and education can leave them in a vulnerable situation. Concludes that debates about training and education cannot take place without referring to the type of work it is appropriate for a practice nurse to perform.	• Highlights importance of clearly defined roles and formal arrangements for training for practice nurses and with co-located services. • In Australia this is likely to require resources from beyond the practice, including a possible role for Divisions.
Atkin K. (1996a)[ii] UK	Authors draw on material from a qualitative study funded by Department of Health and Welsh Office to examine the supervision and management of the colocation of practice nurses in general practice. The paper explores, amongst other things, the nature of the supervisory relationship between GP and practice nurse.	Practice nurses did not see clinical supervision as raising specific problems nor did they express much interest in the more general management issues facing primary health care. Practice nurses, however, felt they did not receive much emotional or administrative support from their employing GP. Nonetheless, most were happy to remain employed by GPs but would attempt to resist the introduction of a more formalised working environment. There were different perception expressed by the funders however, and the authors conclude that managing and supervising the practice nurse resource is not only about practice nursing but raises wider issues about the organisation and delivery of primary health care.	

Reference	What they did	What they found	Implications for Australia
Atkin K. (1996b)[iii] UK	Authors draw on material from a qualitative study funded by Department of Health and Welsh Office, to examine the type of work performed by the colocation of practice nurses and the factors that influence this.	The responses of a range of stakeholders (inc GPs & practice nurses) suggest that a consensus on the future development of practice nursing is unlikely. GPs stressed role development to meet their GMS responsibilities; PNs were focussed on professional issues; purchasing agencies adopted a wider perspective & were concerned with developing an effective & integrated PHC system.	• Making best use of practice nurses will require a process of evolving/ negotiating roles. • If practice nurses are government funded, there is likely to be a difference of expectations between funders, nurses and GPs.
Bollard M (1999)[iv] UK	The project had three broad aims: to establish a practice register of people with learning disabilities in all practices involved in the project; to enable practice nurses to carry out a systematic health check within the practice of people with learning disabilities; and to enable the project nurse to act as a link between specialist learning disability services and the PHCT.	The health checks highlighted unmet health and social needs, which were then met through appropriate referral and intervention, mainly to specialist services. Follow ups were conducted to measure any health gain as a result of the applied Interventions. Evidence of health gain was revealed, pointing to the clinical effectiveness of performing such checks within the PHCTs.	• Reinforces importance of practice registers for identifying groups of patients for preventive care. • Good example of a pro-active role for practice nurse.
Bruce J, (1999)[v] UK - Scotland	Explores the impact of the employment of a community psychiatric nurse (CPN) by a general practice in Aberdeen city to co-ordinate care of discharged long-stay psychiatric patients resettled in hostels. A similar general practice with a comparable group of registered patients was selected as a control group.	Improvements in communication, liaison and drug management were reported in the intervention practice. A primary care-based CPN service dedicated to the care of the chronic mentally ill promoted a smooth transfer of care from long-term institutionalized care to the community setting.	• Highlights potential role for specialist PHC workers within general practices.

Reference	What they did	What they found	Implications for Australia
Carter YH. (1995)[vi] UK	To survey the level of interest and involvement in child injury prevention among general practitioners and their practice teams, and to identify factors associated with current interest. 2/3rds of the respondents considered injury prevention to be part of the general practitioner's role, but less than 1/3rd of these felt that they did enough in this area. Time was cited as the most significant limiting factor.	Practices providing first aid training for staff were associated with an interest in injury prevention. The most appropriate times for offering prevention advice were thought to be during child health surveillance clinics and during treatment of an accident. Awareness about injury prevention opportunities might be improved by emphasising the roles of individual team members and by better addressing the training needs of the whole team.	• RACGP Guidelines for Putting Prevention into Practice recommend that practices employ/nominate a team member as a prevention coordinator. This is easier in group practices than solo or very small practices. • This study also shows the opportunities for opportunistic prevention as recommended by the RACGP guidelines and JAG on GP and Population Health
Cheater F (2001)[vii] UK	Presents the findings of an evaluation of a local clinical supervision scheme for practice nurses in Leicestershire, UK. A baseline and a follow-up postal questionnaire were sent to all practice nurses (including supervisors) and general practice senior partners to find out how far the objectives of the local scheme had been met during the first year of implementation. Two focus groups gathered qualitative data about the process of implementation.	Twelve months after implementation 12% of practice nurses and over two thirds of GPs were unaware of the scheme. 18% of practice nurses reported uptake of supervision through the local scheme and 43% did not know who their local supervisor was. The benefits of involvement were professional development tailored to individual learning needs and regular opportunities to share work-related problems with peers; about a third reported benefits for the practice as well. Reasons for not participating including existing access to peer support, lack of time time and misconceptions about the purpose of clinical supervision.	• Illustrates the difficulty of organising clinical supervision outside the practice.
Dent M, (1997)[viii] UK	Focuses on the changes in the work and responsibilities of practice nurses in two industrial towns in the English Midlands.	In the wake of recent government policies and legislation, practice nursing has undergone major changes, including a rapid growth in the number of practice nurses and expansion of their role. This has given rise to the question of whether this justifies a status as autonomous nurse practitioners.	• Illustrates the potential for developments in the practice nurse role to lead to changes within practices.

Reference	What they did	What they found	Implications for Australia
Dobson R (1999)[ix]	2 pilot projects on nurse led primary care practice, providing access to care without appointments through drop in and after hours surgeries. Patients choose either to see GP or nurse as first point of contact.	1 pilot has shown that 60% of patients choose to see the nurse, so GP skills can be used more efficiently and GP can spend as much time as needed with patients who choose to see GP. High levels of patient satisfaction have been found at one practice, with early results from 2nd pilot producing similar results.	• Shows high level of public acceptance of practice nurses in major primary care role
Jones A et al (2000)[x]	This study explored the views held by GPs, practice nurses and patients about the role of guided self management plans in asthma care	Most professionals opposed the use of the plans and most patients felt they were largely irrelevant to them. The authors conclude that attempts to introduce self guided management plans are likely to be unsuccessful unless they are more patient centred and patient negotiated.	• Highlights need for patient centred approaches, for example in Shared Self Care program
Lightfoot R et al (1999)[xi] NZ	This study aimed to describe the personal characteristics, working conditions, clinical activities and professional development of a representative sample of practice nurses in the Waikato during 1991-1992.	On average, there was one nurse for each solo practice and two in most other practices. While only one-third had received a postgraduate qualification, two-thirds had been to recent professional development courses. The majority had worked as a practice nurse for between one and ten years. Nurses' workload comprised general measurements and assessments, monitoring and surveillance procedures (such as diabetes, asthma and child development), and counseling and women's health activities	• Highlights variety of practice nurse role and importance of training.
Mackereth CJ. (1995)[xii] UK	The aim of the research was to describe the work of practice nurses, with particular reference to health promotion and communication, and to explore the practice nurses' perceptions of their roles.	The research found little uniformity about what practice nurses do, apart from practical tasks. There was poor role definition with regard to screening, health promotion and prevention. Practice nurses perceive themselves as the specialists in health promotion although it was not possible to tell whether they understood the wider issues involved.	• Highlights need for planned and structured care with clear role definitions for preventive care. • Also highlights need for training for practice nurses in patient education and health promotion

Reference	What they did	What they found	Implications for Australia
Mayer R. et al. (1996)[xiii] UK	A group of general practitioners and a practice nurse with experience of family therapy were interested in demonstrating whether family therapy methods could usefully inform general practice consultations. The method involved a colleague or team member in a reflection role	Family therapy ideas can be a helpful framework within which to think about both demanding and ordinary consultations. Inviting a colleague to contribute respectfully could be useful both as a method of teaching, and in resolving difficult or faltering consultations.	• The use of practice nurses or co-located health workers in a GP could be useful resource for GPs in their counselling roles.
Mynors-Wallis L et al (2000)[xiv]	Study involved effectiveness of problem solving treatment when given by practice nurses compared with GPs	Problem solving treatment is an effective treatment for depressive disorders when delivered by suitably trained practice nurses and GPs. There was no difference in the outcome irrespective of who delivered the intervention. The combination of this treatment with antidepressive medication is no more effective that either treatment alone.	• More cost effective for GPs to refer appropriate patients to suitably trained nurses or allied staff for problem solving treatment
Newbury J, (1995)[xv] UK	Outlines the new educational opportunities coming on stream in the UK for practice nurses.	The need for a range of educational programmes is stressed and the key elements of a diploma course for practice nurses in north London are also explained.	• Highlights need for education programs for practice nurses and opportunities for mainstream education facilities.

Reference	What they did	What they found	Implications for Australia
Phillips D (1998)[xvi] UK	Explores aspects of the views of women aged 16-65 years on co-location of practice nurses in the primary health care setting, the extent to which women consult practice nurses, the reasons for consultation and the women's assessments of practice nurses. The findings are from a 3-year research project concerning women's perceptions and experiences of both general practitioners (GPs) and practice nurses.	For most women's health issues, more women preferred to be seen by a GP than a practice nurse, except for breast examination among women aged 49-65 years. Women found practice nurses and GPs equally approachable. Older women, women who saw practice nurses in well-women clinics and women who saw practice nurses in relation to women's health issues had positive views of practice nurses. Women who had not consulted a practice nurse tended not to be aware of their level and range of expertise and think they offered only minor routine services. Women generally did not seem to expect health promotion, disease prevention and family planning from the practice nurse.	• Consumer preferences and expectations will be important in determining successful roles for practice nurses. • GPs and their practices will need to educate patients about the role of the practice nurse.
Rees M, Kinnersley P (1996)[xvii] UK	Reports on an intervention in which a practice nurse saw patients with acute minor illnesses presenting to one general practice. Three hundred and forty-three patients were seen, of whom 96% were managed by the nurse alone and 42% were given prescription.	In a time of increasing pressure on all members of the primary health-care team, interventions such as this need careful consideration and require a review of the relative roles of nurses and general practitioners.	• Highlights extent of roles that practice nurses can undertake.

Reference	What they did	What they found	Implications for Australia
Robertson R, Osman LM, Douglas JG (1997) [xviii] UK	Practice nurses Asthma clinics have become widespread in general practice with nurses now playing an important role in asthma review. However, little is known about training of nurses carrying out reviews and how this affects the nurse role in patient management. Study aimed to discover the level of asthma training of practice nurses carrying out review of adult asthma patients in one Health Authority and to see if this has any effect on their perception of their role.	49% of nurses had or were training for advanced asthma qualification. Nurses without an asthma qualification were significantly more likely to feel that their training was not sufficient for their asthma related work. They were less likely to provide or review a self-management plan, to review patient PEF recordings, to discuss patient worries or to make the initial diagnosis of asthma. Nurses were unlikely to view their role as fully responsible unless they had an asthma qualification.	• Highlights the importance of appropriate training for practice nurses for the clinical conditions they will be dealing with.
Shum C et al (2000)[xix] UK	Multicentre, randomised controlled trial to assess the acceptability and safety of a minor illness service led by practice nurses in general practice. Patients were assigned to treatment by either a specially trained nurse or a general practitioner. Patients seen by a nurse were referred to a general practitioner when appropriate	Patients were very satisfied with both nurses and doctors, but they were significantly more satisfied with their consultations with nurses Practice nurses seem to offer an effective service for patients with minor illnesses who request same day appointments	• Shows high level of public acceptance of practice nurses in major primary care role
Steptoe A (1999)[xx] UK	Practice nurse/health promotion This was a study of the effectiveness of a model whereby practice nurses carried out brief behaviour oriented counselling to reduce smoking and dietary fat intake and to increase regular physical activity.	This model of integrated PHC preventive service delivery led to improvements in healthy behaviour as measured by self reported questionnaires. It is proposed that more extended counselling to assist patients sustain and build on behaviour changes may be required before more differences in biological risk factors emerge	• Suggests strong potential role for practice nurses in encouraging behaviour change for risk factor management

Reference	What they did	What they found	Implications for Australia
Whitecross L (1999)[xxi]	Paper examines practice nurses and nurse practitioners, explores the meaning of collaboration between GPs and nurses and how it has occurred overseas.	The number of practice nurses in UK general practice has increased rapidly since 1987. The numbers increased markedly with the introduction of GP contracts which gave GPs financial bonuses for achieving population targets in preventive care and health promotion. Much of this work has been done by practice nurses. Factors facilitating collaboration between GPs and nurses in advanced practice roles include: • Financial support through the NHS for GPs to employ PNs • Greater workload demands in preventive and chronic care, coupled with declining GP numbers compelled GPs to explore different skill mixes in their practices to meet the demand • GPs, PNs and nurse practitioners were colocated in the same premises	• Suggests that development of practice nurse role may support greater focus on preventive care in general practice. • Highlights importance of financing

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[vii] Cheater F, An evaluation of a local clinical supervision scheme for practice nurses, *Journal of Clinical Nursing*, Volume 10(1).January 2001, 119-131

[viii] Dent M, Burtney E, Changes in practice nursing: professionalism, segmentation and sponsorship, *Journal of Clinical Nursing*, 6(5):355-63, September 1997

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[xv] Newbury J, Educational developments for the practice nurse specialty, *Nursing Times*, 91(14):36-7, April 1995
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[xvii] Rees M, Kinnersley P, Nurse-led management of minor illness in a GP surgery*, Nursing Times*, 92(6):32-3, February 1996
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Question: E01000077
Attachment B

Projects funded by the Department addressing practice nursing include:

1. **Models involving Practice Nurses in EPC:** ***Consortium of Monash Division and including Mornington Peninsula; Sherbrooke and Pakeham; Central Bayside; and Dandenong.***

Mathews, Mary. Presentation to GPDV Annual Conference. March 2001

"To what extent do Practice Nurses address the structural barriers to uptake of the EPC/MBS?"

Using a series of face to face interview and focus groups in 25 practices located across five Divisions of General Practices, the research was able to identify practice structure and describe emerging models by identifying the tasks involved in EPC health assessment for patients over 75 years. Three models emerged:

I. Opportunistic health assessment, completed by the GP. This model is useful for solo GPs or GPs with regular times each week which are predicably quiet, in which the GP can schedule assessments.
II. Contractual employment of the nurse to co-ordinate the assessment and undertake functional assessment. This model is managed by the GP, with some aspects contracted to nursing staff to save time.
III. Internal employment of the nurse within the practice to plan, co-ordinate and assess the process. This process is a systematic recruitment, assessment and follow up process and maximises the hourly rate for EPC involvement.

Table 1: Model Description

	OPPORTUNISTIC	CONTRACTING	INTERNAL EMPLOYMENT
Step One: Preparation		Contract established, roles clarified with nurse	Consider and plan approach, review and clean database and clarify roles
Step Two: Proactive Patient Contact	GP invites patient back and explains process (2 minutes)	GP identifies patient (5 minutes) and provides information to contractor	Nurse identifies patients and sends letters
Step Three: Functional Assessment	GP conducts functional assessment	Contracted nurse completes functional assessment in home and writes report	Nurse completes functional assessment in home and writes report (2 hours)
Step Four: Medical Assessment	GP conducts medical assessment – (30 minutes)	GP sees patient for medical assessment – (30 minutes)	GP sees patient for medical assessment (30 minutes)
Step Five: Finalise Assessments	Finalise report, summary to patient and register for recall	Finalise report, summary to patient and register for recall	Finalise report, summary to patient and register for recall

Benefits of the involvement of Practice Nurses in general practice

- A more planned approach to assessment across the practice's patient population.
- Nurses provide an additional perspective of the patient, as patients will tell the nurse things they "wouldn't bother the doctor with."
- There additional depth of quality to home assessment by a nurse, which enables the GP to better assess issues including nutrition, social isolation and hazards in the home environment.
- The GP role in integrated community care is facilitated by the nurse through liaison with other service providers. Nurses are also able to contribute to care plans or case conferencing.
- Nurses work, rather than compete with, the GP. Nurses are able to lighten the GP's workload by providing specific and complementary skills.

Further information is available on www.monashdivision.com.au under enhanced primary care.

2. Key Factors of Successful professional partnerships between GPs and Nurses:
Fremantle Regional Division of General Practice
Lockwood and Maguire Clinical Integration of General Practice and Nursing 2000.

A local project to facilitate professional collaboration between nurses and GPs was undertaken by the Fremantle Division of General Practice. In conjunction with a nursing agency and state government health department the Division conducted a pilot study entitled Clinical Integration of General Practice and Nursing (Lockwood & Maguire, 2000).

The project placed nurses in four general practices where they consulted with patients and undertook other activities that helped clarify nurse and GP roles within these partnerships. Perceived benefits and barriers to clinical integration were elicited from providers, stakeholders and patients. Characteristics of successful professional partnerships between GPs and advanced practice nurses were identified as:

- Clearly articulated goals;
- Clarified roles and relationships- eg job descriptions and protocols;
- Involvement of people with a positive attitude to working with other health professionals; and
- Use of an agreed evaluation approach which is adaptable to needs of practice.

3. Rural Hospital in the Home
Great Southern Division

This proposal is based on the Homeward 2000 Program. It builds on the knowledge gained from HomeWard 2000 but has a notable change in implementation, by adding the trial of a practice nurse model of care delivery.
It aims to:

- To provide an effective alternative to hospital admission and maintain patients in their own homes
- To provide comprehensive acute care by a clinical team led by the GP
- To increase acute skills of nurses and target specific upskilling for GPs
- To provide cost effective health care to the rural community.

The project will be completed in September 2001.

4. **The Evaluation of the Proposed Primary Care Integration Project in the City of Melville**

Fremantle Regional Division of General Practice

The aim of this project is to evaluate the model of care which includes:

a) Placement of Family Practice Nurses as part of the primary care team at an urban integrated healthcare practice to co-ordinate care to patients identified as eligible for services and likely to benefit from integrated or co-ordinated care; and
b) An education and development processes which aims to increase the awareness and knowledge of appropriate medical, nursing and other key care providers in regard to the co-ordinated development and review of patient care plans.

The evaluation will assess:

(b) The process and impact of the model of care in terms of implementation and co-ordination of care provided through the care plans;
(c) The cost effectiveness of the model of care in terms of an estimate of the dollar costs of project implementation and an estimate of dollar savings to local acute care services;
(d) The key financial and human resources required to expand or transfer the model of care;
(e) The nature of the roles and relationships of medical and nursing staff, and the extent of collaboration and communication, and perceived impediments to integrated models of care;
(f) The nature and extent of the participation of target client groups in the project;
(g) The perceptions of key stakeholders, including the Executive and Board of the Division, and the target client groups of the costs and benefits of the model of care;
(h) The change in attitudes of the key stakeholders involved in the educational and collaborative aspects of the program;
(i) The implications for policy initiatives; and
(j) The key factors of sustainability and transferability of the model of care.

The project will be completed by 31 August 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000078

OUTCOME 4: QUALITY HEALTH CARE

Topic: PRACTICE NURSES

Hansard Page: CA 162

Senator West asked:

(a) I would like to know what you are actually undertaking, what you have done, and what you are planning to do – to ensure that all of those colleges, the appropriate peak professional standard setters, (not the union) are actually beginning to have some involvement and what role you see them having in this division of general practice.

(b) I want to know what you have done and what you are planning to do to make this quantum leap from doctor orientation to a more broad, holistic medical model.

Answer:

(a) The practice nurses Budget initiative is being overseen by a Joint General Practice Partnership Advisory Council/General Practice Memorandum of Understanding (GPPAC/GPMoU) Working Group that has representation from the:

- Royal College of Nursing Australia;
- Royal Australian College of General Practitioners;
- Rural Doctors' Association Australia;
- GPPAC; and
- GPMoU.

This Working Group is holding a workshop on the future of practice nursing in Australia with key stakeholders on 28 and 29 July 2001. Those invited include representatives from the organisations on the Working Group, representatives from peak professional bodies including nursing and consumer groups.

(b) The Commonwealth is working with the states and territories and professional and community groups in a number of areas to encourage more collaboration and integration in the primary health care sector, including:

- The Australian Health Ministers' Conference

  In July 2000, in recognition of the shared responsibilities between the Commonwealth, the States and the Territories in the primary health and community care sector, Health Ministers endorsed collaborative work being undertaken in these areas in consultation with general practice and the primary, community and acute care sectors. This work is focusing on four key areas:

  - integration within and across the primary health care and community care sector;
  - improved interface between primary and acute sectors in relation to pre and post hospital care;
  - improved interface between primary and acute sectors in relation to emergency departments, outpatients and primary care providers; and
  - strengthening the contribution of primary care providers to addressing population health priorities.

- The Enhanced Primary Care Package

  In the 1999-2000 Budget the Commonwealth put in place a range of programs to promote a more integrated approach to service delivery among health professionals and other service providers, including the Enhanced Primary Care package.

  The Enhanced Primary Care package is made up of a range of innovative programs designed to assist people with chronic illnesses and complex care needs (many of whom are older Australians) as well as their carers and the range of health professionals who look after them. It does this by supporting:

  - earlier identification of health problems for older Australians through rebates for annual health assessments;
  - GP involvement in planning care with other medical and non-medical care providers by offering Medicare rebates for care planning and case conferencing, and developing professional education to help GPs put them into practice;
  - further trials of care coordination and more integrated approaches to providing services to test new improved approaches to care;
  - easier access for people to information about available care;
  - improved prevention of falls among older Australians;
  - programs to enable people with chronic conditions to get information about their condition and to share experiences with others who have similar conditions; and
  - further research and development into new uses of information technology to support improved care through the exchange of data between health care providers.

- The More Doctors, Better Services: More Allied Health Services Initiative

  The 2000-2001 Budget focused on the health of Australians living in regional and rural communities and provided funding to a range of programs designed to better meet the needs of these communities, including funding to:

  - increase the number of doctors, specialists and allied health professionals, including nurses, psychologists and podiatrists working in rural and regional Australia;
  - develop new health delivery systems specifically for small communities, targeting chronic diseases such as asthma, heart disease, stroke and renal failure; and
  - expand the Regional Health Services Program which links services and health professionals together and establishes and maintains practical high quality health services packages in communities throughout Australia.

- The 2001-2002 Budget

  The current Budget builds on previous initiatives in the primary health sector. The Government has committed more than $1.4 billion in the last three years to enhance the health of Australians though initiatives in primary health care. The 2001-2002 Budget includes funding:

  - to support doctors in forming effective links with mental health professionals, including psychologists and psychiatrists, and to improve mental health diagnosis and care planning;
  - to encourage medical practitioners to participate with pharmacists in collaborative Domiciliary Medication Management Reviews;
  - for general practices to employ more practice nurses;
  - to improve access to undergraduate nursing education for rural and regional students;
  - for an increase in patient rebates for longer GP consultations which will particularly benefit patients with complex or chronic conditions who may need to spend more time with their doctor;
  - for diabetes treatment and care, including funding to improve prevention, provide earlier diagnosis and improve management of people with diabetes;
  - to improve the clinical care provided to patients with moderate to severe asthma by supporting the evidence-based "3+ visit" asthma management plan;
  - to increase rates of participation in the National Cervical Screening Program; and
  - to improve after hours health care services.

Bush Nursing, Small Community and Regional Private Hospitals Expenditure 2000/2001 (est. May 2001)

STATE	HOSPITAL	2000-2001 $2.1m	2000-2001 to be paid
WA	Geraldton	$ 62,727.00	
SA	Keith	$ 80,590.00	$ 146,781.00
	Moonta		
	Ardrossan		
	Hamley Bridge		
	Mallala		
QLD	Crows Nest & District Co-op	$ 67,929.00	$ 722,125.00
(Darling Downs)	Clifton Co-op		
	Pittsworth & District		
	Allora District Co-op		
	Killarney & District		
	The Wesley Park Haven (Townsville)	$ 21,364.00	$ 15,000.00
	St Stephens (Maryborough)	$ 21,364.00	$ 15,000.00
	Mater Misericordiae (Gladstone)	$ 21,364.00	$ 15,000.00
	Friendly Society (Bundaberg)	$ 21,364.00	$ 15,000.00
	Mater Misericordiae (Bundaberg)	$ 21,364.00	$ 15,000.00
	Mater (Yeppoon)	$ 21,364.00	$ 15,000.00
	Pioneer Valley (Mackay)	$ 15,953.00	$ 14,047.00
	Cooloola Community Private	$ 16,824.00	$ 13,176.00
VIC	Mildura Private	$ 35,203.00	
	Ballan	$ 18,000.00	$ 36,355.00
	Warley	$ 22,273.00	$ 12,727.00
	Walwa		$ 16,364.00
	Chiltern	$ 16,364.00	$ 10,900.00
	Euroa	$ 22,591.00	$ 12,727.00
	Sealake	$ 25,000.00	$ 14,546.00
	Nagambie	$ 42,342.00	$ 16,364.00
	Neerim	$ 19,091.00	$ 12,727.00
	Heyfield		$ 16,364.00
	Yackandandah		$ 16,364.00
NSW	Yeoval Community		$ 25,000.00
	Lithgow Community		$ 25,000.00
	St Vincent's Private (Bathurst)		$ 25,000.00
	Calvary (Wagga Wagga)		$ 25,000.00
TAS	North West Private Hospital (Burnie)		$ 12,900.00
(Workforce research)	Toowoomba (Uni of Sth Qld)	$ 5,114.00	$ 10,228.00
(QI & A discussion paper)	Hoult Consulting	$ 42,470.00	
totals		$ 620,655.00	$ 1,274,695.00
Total Direct Expenditure			$ 1,895,350.00
Program Administration Costs			$ 777,150.00
approx 6 ASL + extensive rural travel			$ 2,672,500.00

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000079

OUTCOME 5: RURAL HEALTH

Topic: RURAL NURSING TRAINING

Hansard Page: CA 196 & CA 197

Senator West asked:

(a) Could you provide the committee with a list of where all the successful 109 are, or the 80 plus the 29 that are obviously in the planning stages, and a brief idea as to what the service is that is being offered?

(b) How much of your budget has been spent in that negotiation and working out process and how much has been spent on actual hands on delivery of a service, or provision of money so they can deliver the service?

Answer:

(a) Please refer to Attachment A.

(b) Regional Health Service Program administered funds have not been used by Departmental staff to negotiate and consult with relevant communities in relation to the development of Regional Health Services. However Program planning funds have been provided to communities to cover the costs associated with developing and investigating the health needs of the community. Program funds spent on planning totals $1.25 million as at 30 May 2001.

Any staffing and other on-costs involved in working with communities is covered by Departmental expenses, which ensures that there is no reduction in the funds available for service delivery.

Regional Health Services Program
Service Delivery and Service Planning Projects

State	Title	Short Description
NSW	Berrigan and Jerilderie RHS Planning Project	Service planning
NSW	North East New England RHS Planning Project	Service planning
NSW	Northern Rivers Western Cluster RHS Planning Project	Service planning
NSW	Shoalhaven RHS Planning Project	Service planning
NSW	Riverina Murray RHS Planning Project	Service planning
NSW	Junee RHS Planning Project	Service planning
NSW	Monaro RHS Planning Project	Service planning
NSW	Bland LGA RHS Planning Project	Service planning
NSW	Riverina Murray RHS Planning Project	Service planning
NSW	Coleambally RHS Planning Project	Service planning
NSW	Enngonia and Weilmoringle RHS	General practitioner, pharmacy and transport services
NSW	Gunning RHS	Podiatry and physiotherapy services
NSW	Murrurundi LGA RHS Planning Project	Service planning
NSW	Macquarie RHS	Cardiovascular disease prevention and rehabilitation programs, dietetics, child and family health, occupational therapy, speech pathology and podiatry
NSW	Tottenham and Tullamore RHS Planning Project	Service planning
NSW	Werris Creek RHS Planning Project	Service planning
NSW	Northern Rivers RHS	Diabetes services, dietetics, community nursing, specialist services
NSW	Eden RHS	Low vision services, health promotion, community development, health education and clinical services
NSW	Mid West Planning Project	Service planning
NSW	Henty RHS Planning Project	Service planning
NT	Urapuntja RHS Planning Project	Service planning
NT	Booroloola RHS Planning Project	Service planning
NT	Katherine West Region RHS	Mobile primary care services including chronic disease screening, child health screening, child immunisation, injury prevention programs, health promotion activities and chronic disease treatment to cattle stations and Aboriginal outstations
NT	Jabiru and District RHS	Health education, drug and alcohol counselling, domestic violence and maternal and child services
NT	Katherine Remote RHS Planning Project	Service planning
NT	Nhulunbuy RHS Planning Project	Service planning
NT	Tennant Creek RHS Planning Project	Service planning

NT	Katherine Step Down Planning Project	Service planning
QLD	North Queensland Planning Project	Service planning
QLD	Clermont RHS	Youth services, mental health services, specialist services;, health promotion, safety and injury prevention, chronic disease management, including diabetes and cardiovascular disease
QLD	Paroo and Bulloo Shire RHS	Podiatry, physiotherapy, diabetes education, youth services, counselling services and transport
QLD	Cooktown RHS	Drug and Alcohol services for the indigenous community
QLD	Mossman RHS	A capital contribution to refurbish the Mossman Hospital to allow the introduction of additional services from this one point of contact.
QLD	Queensland Bush Nursing Association Planning Project	Service planning
QLD	Hospitals Planning Project	Pittsworth Private Hospital – service planning
QLD	Hospitals Planning Project	Killarney Private Hospital – service planning
QLD	Hospitals Planning Project	Allora Private Hospital – service planning
QLD	Hospitals Planning Project	Crows Nest Private Hospital – service planning
QLD	Hospitals Planning Project	Clifton Private Hospital - Planning Project
QLD	Western Queensland RHS	Health promotion, environmental health services, community nursing, indigenous services
QLD	Tambo Shire RHS	Community education and support services, domestic violence and substance abuse support services, crisis counselling,
QLD	Woorabinda Planning Project	Service planning
QLD	Clermont Planning Project	Service planning
QLD	Bauhinia Shire Planning Project	Service planning
QLD	Collinsville Planning Project	Service planning
QLD	Taroom/Wandoan Planning Project	Service planning
QLD	Theodore Planning Project	Service planning
QLD	Agnes Water Planning Project	Service planning
QLD	Central West Planning Project	Service planning
QLD	Cairns Remote Region RHS	Royal Flying Doctor Service mental health services
QLD	South Queensland RHS Planning Project	Service planning
SA	Blanchetown RHS	A capital contribution for a health centre
SA	Burra Clare Snowtown Planning Project	Service planning
SA	Meningie RHS	A capital contribution to establish and operate a medical practice centre
SA	Coober Pedy RHS	Mental health, community nursing and diabetic education services
SA	Coober Pedy Planning Project	Service planning
SA	Eastern Eyre RHS	Health promotion, mental health, social work, youth services, podiatry, speech therapy, dietetics, occupational therapy and physiotherapy
SA	Eyre Peninsular RHS Planning Project	Service planning
SA	Murray Mallee Planning Project	Service Planning

SA	Cummins RHS	Cummins Medical Clinic – redevelopment assistance to provide enhanced and expanded primary care services
SA	Murray Mallee Planning Project	Service planning
TAS	Circular Head RHS	Women's health services, youth health services, family planning services, cancer support services, crisis/intensive support and generic counselling, arthritis support, nutrition / diabetes education, men's health program, mental health services, parenting programs and sexual assault counselling
TAS	Bruny Island Planning Project	Service planning
TAS	Flinders Island RHS	Ante-natal services and specialised access lift
TAS	King Island RHS	Counselling and support services, health promotion and prevention and youth services
TAS	Kentish Municipality RHS Planning Project	Service planning
TAS	Huon Valley RHS	Health promotion services on topics such as youth health, depression/suicide, stress, nutrition, diabetes and rural occupational health and safety
TAS	Glamorgan/Spring Bay Planning Project	Service planning
TAS	George Town RHS	Antenatal classes, pregnant young person support program,youth health, child and adolescent mental health, domestic violence services, exercise for elderly, support programs for the elderly (befriending, home safety, first aid), enhanced co-ordination, access and promotion and support of existing services
TAS	Tasman Peninsular Counselling RHS	Counselling services, health promotion and education
VIC	San Remo RHS Planning Project	Service planning
VIC	Edenhope RHS Planning Project	Service planning
VIC	South Gippsland RHS Planning Project	Service planning
VIC	Yarriambiack Shire RHS	Physiotherapy, occupational therapy, podiatry, community development worker, family & children support, social welfare worker, transport/volunteer coordinator, carer support, communication and information technology support
VIC	High Country RHS	Counselling, community health nursing, occupational therapy, physiotherapy, youth worker, speech pathology, dietetics, podiatry and palliative care
VIC	East Grampians RHS	Community nursing, podiatry, youth services, drug and alcohol counselling, physiotherapy, dietetics and occupational therapy
VIC	Portland/Warnambool RHS	Health promotion, counselling, podiatry, community nursing, dietetics and pharmacy assistance
VIC	Beaufort/Skipton RHS	Community nursing, social work services, podiatry, physiotherapy, occupational therapy and community transport
VIC	Hepburn Shire RHS	Cardiovascular disease management, diabetes and asthma services, mental health and welfare services, health promotion including farm injury prevention and community support services
VIC	Rutherglen RHS	Counselling, diabetes education, women's health, community health nursing, youth services, family support services, podiatry, speech pathology, physiotherapy
VIC	Chiltern RHS	Community nursing
VIC	Otway RHS	Health promotion, mental health, counselling, podiatry, dietetics and physiotherapy
VIC	Far East Gippsland RHS	Drug, alcohol and gambling issues including counselling, community education and group therapy
VIC	Central West Hearing RHS	Expanded hearing services including education, counselling and screening

VIC	Maryborough RHS	Community nursing, social and welfare services, youth services, drug and alcohol counselling, physiotherapy, dietetics and occupational therapy
VIC	Central Highlands Heart Health RHS	47 heart health mini clinics to all towns in the region
VIC	Upper Murray RHS	Care Coordination/case management, community services coordination, health promotion/community development, women's health, mental health, drug and alcohol/youth services
VIC	Cobden RHS	Podiatry, dietetics, social work, physiotherapy, occupational therapy, speech therapy, and youth work
VIC and NSW	Robinvale RHS	Physiotherapy, podiatry, speech therapy, a drug and alcohol worker, social worker, dietician, community nursing, continence advice and audiology
VIC and NSW	Swan Hill RHS Planning Project	Service planning
WA	Narrogin Planning Project	Service planning
WA	North Midlands RHS	A capital contribution has been made for improvements to seven health facilities across seven different shires. The capital will be used for refurbishment, expansion or construction of rooms out of which the new primary care services will be provided.
WA	South East Coast RHS	Health promotion, nutrition, drug and alcohol, mental health, physiotherapy, speech pathology, occupational therapy and community nursing
WA	Gascoyne RHS	Occupational therapy, physiotherapy, speech pathology, diabetes education, nutrition and mental health counselling
WA	Murchison RHS	Child health nursing, health promotion, aboriginal health, alcohol and drug services, community nursing and allied health services. In addition, a capital contribution has been made for a multi-purpose health facility in Wiluna.
WA	Eastern Wheatbelt RHS	Community based health promotion, increased specialist services, allied health services to remote areas, occupational therapy, speech therapy, physiotherapy and dietician. In addition renovation of a building has been funded to accommodate health care providers
WA	Walpole RHS	Health promotion, mental health, community nursing, increased GP services, podiatry, occupational therapy and physiotherapy services
WA	Lake Grace RHS	A capital contribution towards the capital work costs of the Lake Grace Joint Venture Medical Centre
WA	Kimberley Nurse Training	Hospital and clinical nursing training for 16 students based in the Kimberley
WA	Collie Planning Project	Service planning
WA	Murchison RHS	Occupational and speech therapy, paediatric physiotherapy, and podiatry and physiotherapy services
WA	Ngaanyatjarra RHS	Palliative care
WA	Kimberly Counselling RHS	Sexual assault/abuse counselling
WA	Kimberly Aged Care RHS	Continence management, podiatry
WA	North Midlands Planning Project	Service planning
WA	Wheatbelt Planning Project	Service planning
WA	Fitzroy Crossing Planning Project	Service planning
WA	Mid West RHS	diabetes education, physiotherapy, counselling, audiology, podiatry and community health
WA	Wheatbelt Planning Project	Service planning

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000080

OUTCOME 5: RURAL HEALTH

Topic: RAMUS

Hansard Page: CA 227

Senator West asked:

What progress is going on, how many offers there have been, the number that have been accepted the date that they have been paid their scholarship, the date on which last year's recipients were paid their scholarships as well.

Answer:

The initial phase of the 2001 scholarship selection process is complete and eighty scholarships have been offered. Four students did not accept the offer and the RAMUS has been offered to the next four in the order of merit. The Appeals Panel will consider appeals against decisions not to award the RAMUS in June 2001 and establish an order of merit for a limited number of additional scholarships.

As a separate process, Deans of the medical schools were offered the option of submitting a limited number of special case submissions on behalf of unsuccessful applicants they believed had particular circumstances which should be considered. Submissions will be considered and an order of merit established in June 2001.

Payment of the scholarship commences on acceptance of the offer and provision of a completed student agreement form. Payment of scholarships for 2001 commenced in June.

In 2000, scholarship holders were paid the RAMUS as a lump sum. Those awarded the RAMUS in the initial round were paid in October/November and students who successfully appealed a decision not to award the scholarship were paid in November/December.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000082

OUTCOME 7: OFFICE FOR ABORIGINAL & TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL COORDINATED CARE TRIALS

Hansard Page: CA 209

Senator West asked:

Provide copies of the Aboriginal and Torres Strait Islander Coordinated Care Trials – National Evaluation Summary.

Answer:

Copies attached.

(Electronic copy also available on website: http://www.health.gov.au/oatsih/pubs/coord.htm)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000083

OUTCOME 7: OFFICE FOR ABORIGINAL & TORRES STRAIT ISLANDER HEALTH

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM

Hansard Page: CA 210

Senator West asked:

(a) What are the budget funding levels for PHCAP?

(b) Details of the regions involved or selected so far

Answer:

(a) Budget funding levels for PHCAP are shown below and include funding approved in both the 1999-2000 and the 20001-02 Budget.

	1999-00 $m	2000-01 $m	2001-02 $m	2002-03 $m	2003-04 $m	2004-05 $m
2001-2002 Budget	-	-	0.0	0.0	19.7	20.5
1999-2000 Budget	6.8	16.0	22.5	33.5	35.0*	36.5*
Total PHCAP	6.8	16.0	22.5	33.5	54.6*	57.0*

*Indicative figures based on expected parameter indexation.

(b) South Australia

Five regions have been selected for implementation of PHCAP:

- Northern Metropolitan region
- Wakefield region
- Hills Mallee Southern region
- Port Augusta sub-region (including Whyalla, Davenport, Nepabunna and Copley)
- Riverlands region

Central Australia (Northern Territory)

Five regions have been selected for implementation of PHCAP:

- Anmatjere
- Eastern Arrente
- Northern Barkly
- Walpiri
- Luritja / Pintubi

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2000-2001, 28/29 May 2001

Question: E01000084

OUTCOME 7: OFFICE FOR ABORIGINAL & TORRES STRAIT ISLANDER HEALTH

Topic: RENAL DIALYSIS PROGRAMS

Hansard Page: CA 210

Senator West asked:

(a) When do they expect to have the Weipa project up and running?

(b) And the same for the Broome project.

Answer:

(a) The expected date for the Weipa dialysis unit being operational is January 2002.

(b) The expected date for the Broome dialysis unit being operational is August/September 2002.

Federal Government 30% Rebate on Private Health Insurance Estimates Revision

Variation between the Budget 2001-02 and 2000-01 Additional Estimates ($ million)

Year	2001-02 Budget Estimates	2000-01 Additional Estimates	Variation	Variation (%)
2000-01	2,078	2,214	-136	-6.14%
2001-02	2,181	2,358	-177	-7.51%
2002-03	2,291	2,435	-144	-7.51%
2003-04	2,424	2,527	-103	-4.08%
2004-05	2,564	2,634	-70	-2.66%

Background

- At the last Senate Estimates hearing in February, Senator Evans asked for information regarding the percentage of people taking out a product with a front-end deductible or a hospital only product since the introduction of the Rebate. The following table was provided in the answer to this question (without the March 2001 data).

Quarter	Proportion of Persons Covered by Hospital Insurance with Front-end Deductible	Hospital Only Persons as a Proportion of Total Hospital	Proportion of Hospital Members with Exclusionary Cover
Dec-98	38%	25%	6%
Mar-99	38%	24%	6%
Jun-99	38%	24%	6%
Set-99	39%	23%	6%
Dec-99	40%	23%	6%
Mar-00	41%	23 %	7%
Jun-00	50%	24%	5%
Set-00	52%	24%	5%
Dec-00	53%	24%	4%
Mar-O1	**53%**	**23%**	**4%**

Source: Private Health Insurance Administration Council

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Date: May 2001

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000085

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: LIFETIME HEALTH COVER CAMPAIGN

Hansard Page: CA 212

Senator West asked:

What was the financial value of the use of the government's umbrella logo by private health insurers in the Lifetime Health Cover campaign.

Answer:

No money changed hands between the Government and the health insurers for use of the logo and no particular monetary value can be assigned to its use. The financial value, if any, accrued to private health insurers from use of the Lifetime Health Cover logo in health fund advertising cannot be determined. The value of the use of the logo by funds can only be measured by the extent to which the Government's objectives in advertising Lifetime Health Cover were achieved. Basically these objectives were to ensure that the public was told of the Lifetime Health Cover policy change so that people could make a fully informed decision about private health insurance, boost private health insurance membership and improve the risk profile of fund membership. Increases in health insurance participation figures over the life of the campaign illustrate the extent to which these aims were achieved. Figures from the Private Health Insurance Administration Council indicate that participation in private hospital insurance increased from 32.2 per cent of Australians in March 2000 to 45.8 per cent in September 2000. The Lifetime Health Cover advertising campaign – particularly the existence of an easily recognised "brand" or logo (ie the umbrella) in both Government and fund advertising undoubtedly contributed to this result.

An important component of the Government's Lifetime Health Cover campaign was to maximise the interface between Government promotion of the policy and health fund promotion of individual products, in order to increase the overall impact of the Governmental campaign and amplify the dispersal of the campaign message. This approach allowed the Government to extract the maximum value from its expenditure on Lifetime Health Cover advertising, with complementary fund advertising providing extra free publicity for the Government's policy change.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000086

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: GAPS COMMUNICATION CAMPAIGN

Hansard Page: CA 213

Senator Evans asked:

Can you provide a breakdown of the components of the $9.5m media buy being spent of the Gaps Communication campaign.

Answer:

At this stage the breakdown of the proposed Media Buy for the 'Closing the Gap' advertising campaign is as follows:

$ 7,083,888	Free to air and Pay TV
$ 1,735,382	Metro and Regional Print
$ 140,705	NESB print
$ 1,012,500	Outdoor
$ 30,000	Internet (banner advertising)
$10,002,475	Gross Cost
450,111	Less Government Campaign Rebate
$ 9,552,364	Net Cost – GST exclusive

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000087

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: BUSH NURSING, SMALL COMMUNITY & REGIONAL PRIVATE HOSPITALS

Hansard Page: CA 221

Senator West asked:

Last year's budget showed an allocation of $4.1 million for 2000-2001 – that is this financial year – now you are telling me the budget is $2.7 million. What has happened along the way?

Answer:

As provided to the Committee during Senate Estimates hearings - May 2001, $2.7 million has been used in respect of the first group of eligible hospitals in year 1 to assist with service planning and Departmental consultation. The remainder in 2000-01 has been used by the department in establishing the administrative infrastructure for the program e.g. employment of a team of dedicated staff in Central and State Offices, for overheads such as accommodation, and on ensuring that the linkages with other complementary components of the rural health budget package are maintained.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000118

OUTCOME 9: HEALTH INVESTMENT

Topic: TERMINATION OF PREGNANCY WORKING PARTY

Written Question on Notice

Senator Harradine asked:

(a) Does the working party believe that the pamphlets it has drafted protect the rights of women to full and complete information on possible risks and complications of abortion?

(b) Does the Working Party include any members who could represent the community opinion that abortion is medically and morally unacceptable? If so, what are the names of those members?

(c) Why does the Pamphlet claim in two places (pages 7, 10) that second trimester D&E abortions are just as safe as first trimester suction curettage abortions?

(d) Is the Working Group aware that the principal author of the single study the Pamphlet cites to support this statement call this finding "a surprising conclusion" (Jacot et al in American Journal of Obstetrics and Gynecology 168: 633, 1993)? If not, why not? If the group is aware, why is this not included in the pamphlet?

(e) Does the Pamphlet itself contain references to other findings that counter this claim that second trimester D&E is as safe as first trimester suction curettage? [Ferris et al 1996; Grimes 1984; Buehler et al 1985; RCOG 2000] In the light of these citations how can the Pamphlet claim that "there is little information on the risks and safety of D&E at 15 to 20 in comparison with other methods" (page 10)?

(f) Why does the pamphlet devote such considerable attention to abortion using Mifepristone when this drug has not been approved for import into Australia?

(g) The Pamphlet gives considerable prominence to the procuring of abortion by two other drugs, Methotrexate and Misoprostol Have either of these drugs been approved in Australia for abortion?

(h) Is it appropriate for the NHMRC to be promoting the use of drugs for purposes for which they have not been approved?

Answer:

The questions refer to a draft document that the NHMRC is not proceeding with. The draft document has no status as an NHMRC document.

The questions refer to the considerations of a Working Party that is no longer in existence and the work of which will not be completed by the NHMRC. It is no longer possible to comment on the Working Party's consideration of, or intention of addressing, the specific issues raised in the above questions. It is also not possible to comment on the Working Party's consideration of, or intention of reviewing, specific articles in the literature.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000119

OUTCOME 9: HEALTH INVESTMENT

Topic: TERMINATION OF PREGNANCY WORKING PARTY

Written Question on Notice

Senator Harradine asked:

(a) Is Misoprostol teratogenic, known to have caused birth defects in children that it fails to abort, as reported in a paper that the Pamphlet repeatedly cites (Pymar et al 'Alternatives to mifepristone for medical abortion' American Journal of Obstetrics and Gynecology 183 S54-S64, 2000)? If this is case why does the Pamphlet fail to mention this adverse effect of Misoprostol?

(b) Do the authors of two papers (Ferris et al, 'Factors associated with immediate abortion complications' Canadian Medical Association Journal 154 1684, 1996, Buehler et al 'The risk of serious complications from induced abortion', American Journal of Obstetrics and Gynecology 253 18, 1985) cited in the Pamphlet make explicit mention of several ways in which the incidence of abortion-related morbidity may have been substantially understated? If so, why does the Pamphlet fail to mention this fact?

(c) Did the UK Parliamentary Commission of Inquiry (Rawlinson Commission, 1994, 3-4) record expert evidence of significant under-reporting of abortion complications, through delays in the return of the prescribed notification forms to the Health Department, through low follow-up rates in surveys, through the reluctance of some women who experience complications to return to the clinic where the abortion was performed when they can seek medical attention from another doctor, and through some complications not arising until after the prescribed 7-day notification period has expired? If so, why does the Pamphlet make no mention of these findings?

(d) Is the Working Party aware of a detailed study of all 5851 abortions carried out at one Danish hospital between 1980 and 1985, which reported that 6.1% of patients developed complications serious enough to require hospital admission, with a higher rate among women under 25 aborting their first pregnancy, and an average hospital stay was 5.3 days (Heisterberg et al 'Early complications after induced first trimester abortion' Acta Obstetrica et Gynecologica Scandinavica 66 201-204, 1987)? If not, why not? If so, why do they fail to mention it?

(e) Is the Working Party aware of a Danish paper (Kaali et al. 'Frequency and management of uterine perforations in first-trimester abortions', American Journal of Obstetrics and Gynecology 161, 406-408 1989) which reports, following laparoscopic observation of aborted women, a rate of uterine perforation nearly 5 times the higher figure for uterine perforation cited in the Pamphlet? If not, why not? If so, why does the Pamphlet fail to mention it?

(f) Does the pamphlet give as their estimate 'up to 1 in 10' for 'genital tract infection including pelvic inflammatory disease'? Is this estimate based on a paper by Westergaard that, as the title of the paper plainly states, is solely related to pelvic inflammatory disease? If so why does the Pamphlet Westergaard's figure as the figure for 'genital tract infection of varying severity'?

(g) Does Westergaard's figure of 10% PID infection apply only to women testing negative for chlamydia pre-abortion? Does he give a separate figure for those testing positive for chlamydia pre-abortion of 28% developing PID post-abortion? If so why does the Pamphlet not report these figures?

(h) Was the Working Party aware of papers by Duthie et al 'Morbidity after termination of pregnancy in first trimester' Genitourinary Medicine 63 182-187, 1987, and Barbacci et al 'Postabortal endometritis and isolation of chlamydia' Obstetrics and Gynecology 68 686-690, 1986, which leave no room for reasonable doubt that pelvic infection increases the risk of tubal infertility? If not, why not? If so, why did the Working Party say 'It may be that a pelvic infection increases the risk of tubal infertility' (p 20), implying that there is some doubt about it?

Answer:

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000120

OUTCOME 9: HEALTH INVESTMENT

Topic: TERMINATION OF PREGNANCY WORKING PARTY

Written Question on Notice

Senator Harradine asked:

(a) Did the Working party notice, in the papers by Duthie and Barbacci, the finding that a pelvic infection can cause endometritis and salpingitis, making uterine implantation and maintenance of a subsequent pregnancy difficult or impossible? If not, why did they fail to notice? If they did notice, why is there no mention in the Pamphlet of endometritis and salpingitis?

(b) When the Working Party wrote that, on a possible link between abortion and ectopic pregnancy, 'no clear picture has emerged' (p 20), had they read Makinen et al 'Causes of the increase in the incidence of ectopic pregnancy' American Journal of Obstetrics and Gynecology 160 642-646, 1989), which found induced abortion to be one causal factor in 'a recent epidemic of ectopic pregnancy' in Finland? If not, why not? If they had read it, why did they not mention it?

(c) Was the Working Party aware of the finding in Daling et al 'Ectopic pregnancy in relation to previous induced abortion' Journal of the American Medical Association 253 1005-1008, 1985, that multiple abortions seem further to increase the risk of ectopic pregnancy? If not, why not? If they were aware, did they not consider this finding to be important enough for them to advise doctors to warn their patients this increased risk from repeat abortions?

(d) Had any member on the Working Party considered Tharaux-Deneux et al 'Risk of ectopic pregnancy and previous induced abortions' American Journal of Public Health 88 401-405, 1998), reporting a 50% increase in risk of ectopic pregnancy in women who had previously had an abortion, rising to a 90% risk increase where there were two or more abortions? If not, why not? If a member had read it, why was such a finding not mentioned in the Pamphlet?

(e) When the Working Party stated (p 20) that 'no clear picture has emerged' on a possible link between abortion and spontaneous miscarriage of future pregnancies, had they considered Madore et al 'A Study of the effects of induced abortion on subsequent pregnancy outcome' American Journal of Obstetrics and Gynecology 139 516-521, 1981, which reported that 'women with prior abortions had nearly twice as many deliveries in the midtrimester as the control group'? If not, why not? If they had considered it, why did they not report it?

(f) On the same subject, had the Working Party considered Richardson et al 'Effects of legal termination on subsequent pregnancy' British Medical Journal I 1303-1304, 1976, which reported an overall fetal loss rate of 17.5% among women who had aborted a previous pregnancy, rising to 45.5% where cervical laceration was identified, adding that, since the study excluded women admitted as emergencies to gynaecological wards, 'the true picture among these women is almost certainly far worse'? If not, why not? If they had considered it, why did they not report it?

(g) Had the Working Party considered Wright et al 'Second-trimester abortion after vaginal termination of pregnancy' The Lancet 1 1278-1279, 1972, which concluded that 'all patients who have had a vaginal termination of pregnancy should be judged as being at risk of having a second-trimester [spontaneous] abortion in their subsequent pregnancy'? If not, why not? If they had read it, why did they not report it?

(h) Had the Working Party read Ratten et al 'The Effect of termination of pregnancy on maturity of subsequent pregnancy' Medical Journal of Australia 1 479-480, 1979), which 'revealed an alarmingly high incidence of cervical incompetence' following abortion, and added: 'It is obvious that patients undergoing termination of pregnancy should be told of the risk of cervical incompetence. They must know that their future obstetrician should be informed of the termination'? If not, why not? If they had read it, why did they not report it?

Answer:

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000121

OUTCOME 9: HEALTH INVESTMENT

Topic: TERMINATION OF PREGNANCY WORKING PARTY

Written Question on Notice

Senator Harradine asked:

(a) When the Working Party decided to consider psychological effects under the heading of long-term risks (p 19), did they notice that, of the 72 studies of psychological sequelae surveyed for the Pamphlet, 45 cover a period of one year or less post-abortion, including 23 covering a period of one month or less post-abortion, and 8 covering a period of 1 hour or less post-abortion? Can they explain what relevance studies with such a short time span can have to assessing long-term risks of adverse psychological outcomes to abortion?

(b) Did the Working Party read David 'Post-abortion and post-partum psychiatric hospitalisation' CIBA Foundation Symposium 115 150-161, 1985. a Danish register linkage study which found that psychiatric hospital admissions in the first 3 months were 50% higher after abortion than after childbirth, and 4 times higher among aborted women who were divorced or separated? If not, why not? If they had read it, why did they not report it?

(c) Did the Working Party read Gissler et al 'Suicides after pregnancy in Finland 1987-1994: register linkage' British Medical Journal 313 1431-1434, 1996, a register linkage study of all women of childbearing age in Finland, which found that the suicide rate following abortion was more than 3 times the average suicide rate for women age 15-49, and more than 6 times the suicide rate for women who gave birth? If not, why not? If they had read it, why did they not report it?

(d) Was the Working Party aware of the summing-up by Sim in the concluding section on psychiatric problems in pregnancy, childbirth and abortion in his general textbook on psychiatry (Sim A Guide to Psychiatry Edinburgh 1981, 639). that 'with abortion, the problem is certainly not one of preventing mental illness, for abortion is not a prophylactic against psychosis, but a precipitant'? If not, why not? If they had read it, why did they not report it?

(e) Had the Working Party read the report of the Rawlinson Commission to theUK Parliament in 1994 of a comprehensive estimate of 87% of post-abortion women suffering some psychological symptoms, with 15% seeking some form of professional help? If not, why not? If they had read it, why did they not report it?

(f) Was the Working Party aware of an analysis by Zolese et al of 20 years' published research on this subject, suggesting a minimum figure of 10% for 'marked, severe or persistent' depression and anxiety (Zolese et al 'Psychiatric complications of therapeutic abortion' British Journal of Psychiatry 160 742-749, 1992)? If not, why not? If they had read it, why did they not report it?

(g) Did the Working Party consider that, even at Zolese's figure of 10%, with a procedure as frequently performed as abortion this means over 8,000 additional cases of 'marked, severe or persistent' depression and anxiety in Australia, year after year? Did not the Working Party consider these numbers to constitute a significant public health problem? If not, why not?

(h) Had the Working Party read Kumar et al 'Prospective study of emotional disorders in childbearing women' British Journal of Psychiatry 144 35-47, 1984, reporting that aborted women have been found to be at higher risk of depressive illness early in a subsequent pregnancy? If not, why not? If they had read it, why did they not report it?

Answer:

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000122

OUTCOME 9: HEALTH INVESTMENT

Topic: TERMINATION OF PREGNANCY WORKING PARTY

Written Question on Notice

Senator Harradine asked:

(a) Had the Working Party considered Bradley 'Abortion and subsequent pregnancy' Canadian Journal of Psychiatry 29 494-498, 1984, reporting that aborted women suffer more often from anxiety before a subsequent birth, and from depression following that birth? If not, why not? If they had considered it, why did they not report it?

(b) Had the Working Party considered Selby The Mourning After, Grand Rapids 1990, or White 'One doctor's experience' in Doherty Post-Abortion Syndrome Dublin 1995) reporting the experience of clinicians that subsequent reproductive events - pregnancy, miscarriage or live birth - can unexpectedly precipitate symptoms that have been dormant, sometimes for years? If not, why not? If they had considered it, why did they not report it?

(c) Had the Working Party read Reist, Giving Sorrow Words: women's stories of grief after abortion (Sydney 2000), which reports repeated cases of the same pattern: the unexpected precipitation of dormant symptoms during and following a subsequent pregnancy? If not, why not? If they had read it, why did they not report it?

(d) If the Working Party had not made itself familiar with the papers by David, Gissler, Zolese, Kumar, and Bradley, the books by Sim, Selby, Doherty and Reist, and the 1994 Report to the UK Parliament, how could they justify their claim to have based their conclusions on a comprehensive review of the relevant medical literature?

(e) Had the Working Party read Brind et al 'Induced abortion as an independent risk factor for breast cancer: a comprehensive review and meta-analysis' Journal of Epidemiology and Community Health 50 481-496, 1996), reviewing and analysing all published papers since 1957, and finding that nearly all the research published since 1957 reports an association between induced abortion and breast cancer? If they have not read it, how can such a widely-discussed paper have escaped their notice? If, on the other hand, they have read it, why does no mention of it appear, either in the text of the Pamphlet, or in the References?

(f) Had the Working Party read Andrieu et al 'Familial risk, abortion, and their interactive effect on the risk of breast cancer' British Journal of Cancer 72 744-751, 1995), reporting Australian research which found abortion to be an even stronger indicator of breast cancer risk than a family history of the disease? If not, why not? If so, why did they not mention it?

(g) Had the Working Party read Russo 'Susceptibility of the mammary gland to carcinogenesis' American Journal of Pathology 100 497-511, 1980), which confirmed an abortion-breast cancer link in animal studies? If not, why not? If so, why did they not mention it?

(h) Was the Working Party aware of Daling et al 'Risk of breast cancer among young women: relationship to induced abortion' Journal of the National Cancer Institute 86 1584-1592, 1994, or Remmenick 'Induced abortion as a cancer risk factor: a review of the epidemiological evidence' Journal of Epidemiology and Community Health 44 259-264, 1990), where a probable hormonal mechanism, in the effect of high estrogen levels on breast tissue during pregnancy and the abrupt fall in estrogen levels when abortion is induced, has been suggested to explain the link that appears to exist between abortion and breast cancer? If not, why not? If so, why did they not mention it?

Answer:

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000123

OUTCOME 9: HEALTH INVESTMENT

Topic: TERMINATION OF PREGNANCY WORKING PARTY

Written Question on Notice

Senator Harradine asked:

(a) Have the Working Party read Melbye et al 'Induced abortion and the risk of breast cancer' New England Journal of Medicine 336 81-85, 1997), which they cite (p19) as conclusive in supporting their dismissal of an abortion-breast cancer link? If they have read it, how can they justify their statement that Melbye was unable to detect any link, even in 'particular sub-groups of women', when in fact the Melbye paper reports a higher risk of breast cancer with second-trimester abortions, and abortions in younger women?

(b) Were the Working Party aware that the Melbye paper has itself been criticised for major faults in its selection (and exclusion) of data from the Danish registry, and in its statistical adjustment of that data (Brind 'Re:Induced abortion and the risk of breast cancer' New England Journal of Medicine 336 1834, 1997), with the controversy continuing in Epidemiology 11 234-235, 2000? If not, how can they have been unaware of it? If, on the other hand, they were aware of it, why did they make no mention of it?

(c) Were the Working Party aware of a forthcoming actuarial study, to be published shortly by the Royal Statistical Society, which accepts the evidence that induced abortion has contributed to the disturbing increase in the incidence of breast cancer in recent decades and, calculating an annual increase of 1.6% in diagnosed cases in England and Wales (slightly less in Scotland, where the abortion rate is lower) and concludes that the number of cases diagnosed each year will rise from 30,000 to more than 50,000 by 2030? If not, why not? If so, why did the group not mention it?

(d) Having failed to deal with the evidence reported in the Brind meta-analysis, and the papers by Andrieu, Daling, Remmenick, and Russo, how can the Working Party claim to be across the relevant scientific literature and to be in a position to dismiss or portray as minimal any link between abortion and breast cancer?

Answer:

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ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000115

OUTCOME 9: HEALTH INVESTMENT

Topic: PRIMATE RESEARCH FACILITIES

Written Question on Notice

Senator Woodley asked:

(a) Where are the locations of any primate holding facilities of any Commonwealth agencies, authorities, companies or departments?

(b) How many primates are held in each facility?

(c) For each facility, please provide current information for each species: numbers; ages; sexes; state of health.

(d) Why have the facilities for primates been established?

(e) What are the expenses to the Commonwealth per facility?

(f) Please provide the history of births and deaths in these primate facilities including, but not restricted to (please date all information): number of births per species and by sex; number of deaths per species and by sex. For each death please provide: species, date, age, sex, attributed cause of death and please provide the documentation associated with the death

(g) What is the range of causes of death of primates in the facility?

(h) How many of the primates in the facility are used for research or any related purposes?

(i) What is the number of research protocols each animal has been subjected to?

(j) How many of the deaths are as a result (direct or indirectly) of research procedures? For each death please state: What was the history of procedures that the animal underwent? What was the species, age, sex, date, attributed cause of death.

(k) Are any primates being used under licence (or any other method) for research (or any other purpose) by bodies other than Commonwealth agencies, authorities, companies or departments?

(l) What are the names of the bodies and their locations?

(m) What is the revenue derived by the Commonwealth from engaging in this practice?

(n) What is the nature of the activity conducted by each institution?

(o) Does any of the activity involve any form of research or any related activity?

(p) What is the revenue that the body has derived from the use of the primates?

(q) What health, safety, housing, treatment standards are requested or enforced by the Commonwealth for these primates?

(r) How many primates are held by each body and at which location?

(s) Please provide the history of births and deaths while at these facilities including, but not restricted to (please date all information):number of births per species and by sex; number of deaths per species and by sex; for each death please provide: species, date, age, sec, attributed cause of death.

(t) What is the range of causes of death of primates in the facility?

(u) How many of the primates in the facility are used for research or any related purposes?

(v) What is the number of research protocols each animal has been subjected to?

(w) How many of the deaths are as a result (direct or indirectly) of research procedures? For each death please state: What was the history of procedures that the animal underwent? What was the species, age, sex, date, attributed cause of death. Please provide documentation associated with the death.

(x) Please provide names and numbers of relevant people if I need to obtain any further information on the above series of questions.

Answer:

(a) The NHMRC is not a regulatory body for animal welfare. Regulation of animal welfare is the responsibility of State and Territory governments, and there is no Commonwealth animal welfare legislation. Other Commonwealth agencies, authorities, companies or departments are not required to report to the NHMRC on animal welfare matters. This response is limited to matters that are the responsibility of the NHMRC.

The NHMRC Animal Welfare Committee (AWC) is an advisory group reporting to the NHMRC Research Committee on the conduct and ethics of animal experimentation. With the approval of NHMRC Council, the AWC develops and implements ways of ensuring that all animal experimentation funded by the NHMRC is in accord with the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes.

The NHMRC Research Committee currently provides partial funding to support three non-human primate holding and breeding facilities. These are the:

- National Baboon Colony, under the control of the Royal Prince Alfred Hospital, Sydney;
- National Macaque Facility, under the control of The University of Melbourne; and
- National Marmoset Facility, under the control of Monash University, Melbourne.

(b) There are currently 123 animals at the National Baboon Colony, 147 at the National Macaque Facility, and 148 at the National Marmoset Facility.

(c) National Baboon Colony. The Colony currently holds 3 newborn animals of unknown sex (see Note), 19 animals aged 0-2 years (9 male, 7 female), 15 animals aged 2-5 years (9 male, 6 female), and 89 animals aged 5 years or more (49 male and 40 female), all *Papio hamadryas*. All animals were healthy as recorded on 12 June 2001.
National Macaque Facility. The Facility currently holds 93 *Macaca nemestrina*. Of these, there are 19 neonates of unknown sex (see Note), 34 juveniles (8 males and 12 females), and 40 adults (5 male and 35 female). There are also 54 *Macaca fascicularis*. Of these, there are 10 neonates of unknown sex (see Note), 20 juveniles (8 males and 12 females) and 24 adults (5 male and 19 female). All animals were in optimal health when examined by the facility veterinarian on 8 June 2001.
National Marmoset Facility. The Facility currently holds 27 animals aged under 1 year (11 male, 7 female and 9 of unknown sex), 40 males and 51 females between 1-5 years, and 20 males and 10 females between 5-10 years, all *Callithrix spp*. All animals are in excellent condition.
Note: delayed identification of the sex of the neonate, eg at 6 months of age, results in less injury, and less likelihood of rejection by the mother.

(d) The NHMRC is the main funding body for biomedical research in Australia, and animal experimentation is crucial for the success of a major proportion of this research. The NHMRC recognises that, being closely related to humans, non-human primates can provide unique and invaluable models for medical research purposes.

The three NHMRC-funded non-human primate breeding facilities were established:

- to ensure the continued availability of the three most-commonly used species for biomedical research in Australia-baboons, macaques and marmosets;
- to ensure the welfare of these animals is protected and that they receive appropriate care and housing;
- to remove the necessity for institutions to maintain their own small colonies;
- to remove the necessity to import these animals into Australia; and
- to protect these species in the wild by breeding them in captive colonies.

NHMRC-funded institutions using non-human primates are required to comply with the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes (the 'Code'), and with all relevant State and Territory legislation. The Code promotes animal welfare as a key aspect in the use of animals in research. It also encapsulates the principles of replacement of animals with other methods, a reduction in the number of animals and a refinement of techniques to reduce the impact on animals used in scientific and teaching activities.

(e) In 2000, the NHMRC contributed towards the costs of these facilities by providing funding of $30,000 to the National Baboon Colony, $72,000 to the National Marmoset Facility, and an estimated $80,000 to the National Marmoset Facility. An additional $63,000 was provided to the National Marmoset Facility to subsidise the cost of animals to NHMRC-funded researchers. Funding for 2001 has not been finalised.

(f) National Baboon Colony. To date in 2001 there have been two male and three female births, and three births of unknown sex (see Note), all *Papio hamadryas*. There has been one death, an adult aged 23 years with lymph node cancer (native disease).
National Marmoset Facility. To date in 2001, there have been 27 births of unknown sex (see Note), all *Callithrix spp*. There have been seven neonate deaths (three stillborn, two animals humanely killed due to illness, two deaths) due to Epstein-Barr Virus related causes and birthing difficulties. There have been four adult deaths (one male, three female) due to congenital adrenal cortical hypoplasia, dystocia fetus and wasting syndrome.
National Macaque Facility. To date in 2001, there have been six births of unknown sex (see Note) for *Macaca nemestrina*, and two births of unknown sex (see Note) for *M. fascicularis*. There have been two deaths of six-year-old female *M. nemestrina* due to salmonella. Amongst *M. fascicularis*, there has been one death of a male aged 17 years from diabetes, and two deaths of females (aged 3 and 2.5 years) from salmonella.
Note: delayed identification of the sex of the neonate, eg at 6 months of age, results in less injury, and less likelihood of rejection by the mother.

(g) Deaths in the three NHMRC-funded facilities range from stillbirths, birthing difficulties and native disease to aged-related diabetes, and Epstein-Barr Virus-related and congenital causes. The salmonella that caused the deaths of four macaques is suspected to have been brought in on the fruit from the market.

(h) Currently, all animals over five years of age at the National Baboon Colony (72 per cent of the total colony) are allocated for approved studies. The National Marmoset Facility has currently allocated 44 animals (30 per cent of the total colony) for approved projects at research institutions. The National Macaque Facility is currently holding 37 animals (25 per cent of the total colony) prior to dispatch for approved research projects.

(i) The Australian Code of Practice for the Care and Use of Animals for Scientific Purposes requires the express approval of an institutional Animal Ethics Committee (AEC) for the use of animals for more than one study, either in the same or different projects. The AEC must be satisfied that none of the procedures cause the animals pain or distress, or that any subsequent studies produce little or no pain or biological stress to the animals (eg modifying diet, blood samples, non-invasive recording procedures) and that they have recovered fully from the first study. Appropriate re-use of animals may reduce the total number of animals used in a project, reduce distress, or avoid pain to other animals.

Animals from the National Baboon Colony are available for more than one minor procedure only after a six-month recovery period and AEC clearance. Animals from the National Marmoset Facility are only issued to one AEC protocol, and it is left to the AEC to decide if more than one procedure is permitted. Animals at the National Macaque Facility are available for more than one minor procedure only after recovery from the minor procedures and with AEC approval.

(j) There have not been any deaths in 2001 as a result of research procedures at any of the three NHMRC-funded facilities.

No research is conducted at the National Marmoset and Macaque Facilities. Prior to research being undertaken on these animals, approval is required from an institutional Animal Ethics Committee (AEC), and the animals are then moved out of the facility. In the case of the National Baboon Colony, research may be undertaken on premises that are the responsibility of the facility's primary funding body, but approval is required from both its own AEC and from an AEC from the institution funding the study.

Information on the death of animals from the three NHMRC-funded facilities as a result of research procedures is held by the institution responsible for each study. For example, this information may be held by the institution's AEC, and by the chief investigator for the study.

All NHMRC-funded institutions are required to comply with the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes. Under this code, investigators must anticipate and take all possible steps to avoid or minimise pain and distress in the animals, including ensuring the animals are adequately monitored, acting promptly to alleviate pain and distress, and using anaesthetic and other agents appropriate to the species. When it is necessary to kill an animal, researchers must use humane procedures that avoid distress, are reliable, and produce rapid loss of consciousness without pain until death occurs.

(k) The NHMRC is not a regulatory body for animal welfare. Regulation of animal welfare is the responsibility of State and Territory governments. The NHMRC does not hold information about the use of non-human primates outside NHMRC-funded institutions. Requests for information on any primates being used for research (or any other purpose) by bodies other than NHMRC-funded institutions may be directed to the relevant State or Territory government.

The three NHMRC-funded non-human primate breeding facilities are permitted to provide animals to researchers for medical research purposes only, and only to institutions that have provided Animal Ethics Committee (AEC) clearance for the research. AECs are required under the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes to ensure that animal care and use within institutions is conducted in compliance with the Code.

(l) To date in 2001, animals from the three NHMRC-funded facilities have been provided to the following institutions:

University of Melbourne
Monash University, Melbourne
University of Sydney
Royal Prince Alfred Hospital, Sydney
Sydney University
CSL Animal Health, Melbourne
Liverpool Hospital, Sydney
Alfred Hospital, Victoria
Concord Hospital, Sydney

(m) The Commonwealth derives no revenue from the provision by the NHMRC of funding support for non-human primate facilities. Revenue from the provision of animals by each facility to institutions for medical research aims to help meet the cost of housing and caring for the animals.

(n) The institutions using non-human primates are involved in medical research, and the animals are used strictly for medical research purposes.

(o) The institutions using non-human primates are involved in medical research, and the animals are used strictly for medical research purposes.

(p) The NHMRC provides financial support to three non-human primate facilities to enable Australian researchers access to healthy animals for the purposes of medical research. This research aims to increase health-related knowledge and treatments, which benefit all Australians. Institutions with a sound track record in research are able to attract further funding support through the NHMRC's normal grant processes.

(q) All NHMRC-funded primate facilities and medical research institutions are required to comply with the Australian Code of Practice for the Care and Use of Animals for Research Purposes (the 'Code'). They must also comply with the NHMRC Policy on the Use of Non-Human Primates in Medical Research (the 'Policy'), and with all relevant Commonwealth and State and Territory legislation.

The Code covers all aspects of animal use and care for scientific purposes. It stipulates regular inspections of all animal housing and laboratory areas within institutions by Animal Ethics Committee (AEC) members, proper record keeping on the acquisition, breeding, health, care, housing, use and disposal of animals, and immediate notification and cessation of any activity in breach of the Code. Standards of animal care, housing, environmental factors and nutrition must be high and suit the needs of the species.

The Policy provides guidelines on specific aspects of non-human primate management, housing and care which require special consideration. It also expects investigators and AEC members to seek expert advice from either the non-human primate facilities, or other qualified personnel, as appropriate.

The NHMRC Animal Welfare Committee also inspects the three NHMRC-funded non-human primate facilities.

(r) Information about the number of primates held by each institution, and their location, is not held by the NHMRC. Please refer to the response at (l) above for institutions to which primates from the National Baboon Colony and the National Macaque and Marmoset Facilities have been provided in 2001. In addition, please refer to the response at E01000117 (a-f) (BE 28/29 May 2001) for current NHMRC-funded grants using non-human primates.

The timing, number and location of animals for each research grant depend upon the needs of individual researchers. The movement of animals from breeding facilities to research institutions, and the location and care of these animals, are managed by each institution. Information about animals held by institutions are recorded, for example, by Animal Ethics Committees, the chief investigator for each project, and the person-in-charge of the management of the day-to-day care of the animals at each institution. This information is not held by the NHMRC.

(s) Information about animals at research institutions, including data on the species of animal and their age, sex and health, is held by the relevant institution, for example by its Animal Ethics Committee and by the chief investigator for each research study, and is not held by the NHMRC.

(t) Information about animals held at research institutions, including the causes of death for these animals, is held by the relevant institution, for example by its Animal Ethics Committee and by the chief investigator for each research study, and is not held by the NHMRC.

(u) Information about animals held at research institutions, including the purposes to which these animals are used, is held by the relevant institution, for example by its Animal Ethics Committee and by the chief investigator for each research study, and is not held by the NHMRC.

(v) Information about animals held at research institutions, including the number of research protocols to which each animal has been subjected, is held by the relevant institution, for example by its Animal Ethics Committee (AEC) and by the chief investigator for each research study, and is not held by the NHMRC. Under the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes, individual animals must not be used in more than one study without the express approval of the AEC.

(w) Information about animals held at research institutions, including the number of deaths as a result of research procedures, is held by the relevant institution, for example by its Animal Ethics Committee and the chief investigator for each research study, and is not held by the NHMRC.

(x) Director, Research Policy, Centre for Research Management, Office of the NHMRC

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000116

OUTCOME 9: HEALTH INVESTMENT

Topic: ANIMAL ETHICS COMMITTEES

Written Question on Notice

Senator Woodley asked:

(a) How many animal ethics committees does the Commonwealth have when considering all government agencies, authorities, companies and departments?

(b) For each animal ethics committee please provide: location of the committee; who is on the committee and why they are on the committee; facilities that the committee supervises; species and number of animal at each location.

(c) Please provide the deliberations of each committee.

(d) Please provide names and numbers of relevant people If I need to obtain any further information on the above series of questions.

Answer:

(a) The NHMRC is not a regulatory body for animal welfare. Regulation of animal welfare is the responsibility of State and Territory governments, and there is no Commonwealth animal welfare legislation. Other Commonwealth agencies, authorities, companies or departments are not required to report to the NHMRC on animal welfare matters. This response is limited to matters that are the responsibility of the NHMRC.

The NHMRC does not conduct any research using animals and does not have any animal ethics committees. It funds biomedical research conducted at various institutions on the basis of peer-review of merit and open competition.

The NHMRC Animal Welfare Committee (AWC) is an advisory group reporting to the NHMRC Research Committee on the conduct and ethics of animal experimentation. With the approval of NHMRC Council, the AWC develops and implements ways of ensuring that all animal experimentation funded by the NHMRC is in accord with the Australian Code of Practice for the Care and Use of Animals for Scientific Purposes (the 'Code').

The NHMRC requires all its funded institutions to comply with the Code. Under the Code, all institutions which use animals for scientific purposes must establish one or more Animal Ethics Committees (AECs). AECs are directly responsible to the governing body of the institution and are required to ensure that animal care and use within the institution is conducted in compliance with the Code.

(b) Information about the location, membership, composition and functions of institutional Animal Ethics Committees (AECs) is held by individual institutions and is not held by the NHMRC. Release of information about AECs is at the discretion of individual institutions. The NHMRC Animal Welfare Committee is currently considering a requirement for institutions to provide this information to them on an annual basis.

The Australian Code of Practice for the Care and Use of Animals for Scientific Purposes requires AECs to have at least four members, each separately meeting a specific category of membership. Thus, all AECs must include a veterinarian, a person experienced in the use of animals for research or teaching, a person experienced in animal welfare, and an independent person with no previous experience in the use of animals for research or teaching.

(c) Deliberations of Animal Ethics Committees (AECs) are held by individual institutions and are not held by the NHMRC. Release of AEC records is at the discretion of individual institutions.

(d) Director, Research Policy, Centre for Research Management, Office of the NHMRC

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000117

OUTCOME 9: HEALTH INVESTMENT

Topic: NATIONAL HEALTH AND MEDICAL RESEARCH COUNCIL

Written Question on Notice

Senator Woodley asked:

(a) How many grants have been made that involve using primates?

(b) Who/what body was the grant given to?

(c) What was the purpose of the grant?

(d) What was the dollar value of the grant?

(e) What is the purpose of the research or activity?

(f) What were the species, sex and numbers of primates used for each project?

(g) Is the NHMRC considering funding anything that involves primates? Who or what body or organisation? For what purpose? What amount? What is the stated purpose of the research or activity? What are the species and numbers of primates proposed?

(h) Please provide names and numbers of relevant people If I need to obtain any further information on the above series of questions.

Answer:

(a-f) The NHMRC currently funds twelve grants directly or indirectly involving the use of living non-human primates.

Detail held by the NHMRC on the number and sex of the animals for each research project is limited to the information provided by researchers in their applications for funding. Hence, the numbers below refer only to the number and sex of animals proposed to be used for each project at the time of lodging the application. The number of animals actually used is often significantly less, reflecting the difference between the amount of funding sought and the amount of funding provided. The actual number of animals used for each project is held by the relevant institution, such as the Animal Ethics Committee and the chief investigator, and is not held by the NHMRC. For this reason, all animal numbers in the list below are approximate only.

1. Institution: Monash University
   Type of Grant: Project Grant
   Title of Project: The output pathways of the basal ganglia
   Total Grant Funding: $363,830
   Purpose of Project: Research into Parkinson's Disease
   Non-Human Primates: approx. 15 *Macaca mulatta/nemestrina*
2. Institution: Monash University
   Type of Grant: Project Grant
   Title of Project: Ovarian grafting in a primate model
   Total Grant Funding: $286,425
   Purpose of Project: Research into fertility/IVF
   Non-Human Primates: approx. 32 female, 4 male *Macaca nemestrina*
3. Institution: Monash University
   Type of Grant: Project Grant
   Title of Project: Extrastriate vision in primates
   Total Grant Funding: $407,252
   Purpose of Project: Research into human vision
   Non-Human Primates: approx. 60 *Callithrix spp*., 15 *Macaca fascicularis*, 5 *Papio hamadryas*
4. Institution: University of Sydney
   Type of Grant: Project Grant
   Title of Project: Distribution of neurotransmitter receptors on identified cell populations in the primate retina
   Total Grant Funding: $421,140
   Purpose of Project: Research into the Central Nervous System
   Non-Human Primates: approx. 20 *Callithrix jacchus*
5. Institution: University of Sydney
   Type of Grant: Project Grant
   Title of Project: Structure and function of the third geniculocortical pathway in primates
   Total Grant Funding: $293,863
   Purpose of Project: Research into human visual function
   Non-Human Primates: approx. 30 *Callithrix jacchus*
6. Institution: University of Sydney
   Type of Grant: Scholarship (see Note)
   Title of Project: Parallel processing in the primate visual system
   Total Grant Funding: $54,777
   Purpose of Project: Research into human visual function
   Non-Human Primates: approx. 30 *Callithrix jacchus*
7. Institution: University of New South Wales
   Type of Grant: Project Grant
   Title of Project: Neural mechanisms in tactile, kinaethetic and pain sensation
   Total Grant Funding: $626,135
   Purpose of Project: Research into central neural mechanisms in sensation
   Non-Human Primates: approx 50 *Callithrix spp*.
8. Institution: University of New South Wales
   Type of Grant: Project Grant
   Title of Project: Pre-clinical trial with fetal pig insulin-producing cells
   Total Grant Funding: $145,760
   Purpose of Project: Research into Diabetes
   Non-Human Primates: approx. 18 *Papio hamadryas*

9. Institution: Australian National University
   Type of Grant: Project Grant
   Title of Grant: Interactions between afferent channels in vision: basic neurophysiology and implications for the pathology of dyslexia
   Total Grant Funding: $420,020
   Purpose of Project: Research into human vision
   Non-Human Primates: approx. 28 *Macaca fascicularis*, 9 *M. nemestrina*
10. Institution: University of Melbourne
    Type of Grant: Project Grant
    Title of Grant: Changes in pathways mediating touch in the macaque's hand following section at peripheral and central levels
    Total Grant Funding: $142,054
    Purpose of Project: Research into nervous system response to injury
    Non-Human Primates: approx. 18 *Macaca fascicularis*
11. Institution: University of Melbourne
    Type of Grant: Project Grant
    Title of Grant: Neural signals from the digits
    Total Grant Funding: $211,792
    Purpose of Project: Research into hand function
    Non-Human Primates: approx. 12 *Macaca nemestrina*
12. Institution: University of Queensland
    Type of Grant: Fellowship (see Note)
    Title of Grant: Anatomical substrates for functional diversity and plasticity in the adult primate cortex
    Total Grant Funding: $256,977
    Purpose of Project: Research into cortical function
    Non-Human Primates: approx. 8 *Macaca fascicularis*

Note: Scholarship and Fellowship grants cover researchers' costs, eg salaries, overseas travel & training, and hence do not require animal ethics approval. The recipient of this Scholarship/Fellowship is, however, involved in an AEC-approved study using non-human primates.

(g) The NHMRC is currently considering applications for research funding for 2002. The outcome of this funding round will be announced later in the year.

The NHMRC has also recently supported a proposal by Monash University under the Major National Research Facilities Program to construct a new $10 million National Primate Facility in Victoria. The proposed breeding and holding facility would combine the existing National Macaque and Marmoset Facilities and hold about 150 animals. As well as providing optimum conditions for the animals, the proposed facility would be a reference centre for the dissemination of knowledge and provision of expert technical assistance to researchers, Animal Ethics Committees, and those interested in the use and care of captive non-human primates. The outcome of this proposal will be announced by AusIndustry later in the year.

(h) Director, Research Policy, Centre for Research Management, Office of the NHMRC

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000089

OUTCOME 9: HEALTH INVESTMENT

Topic: CLINICAL SCHOOLS

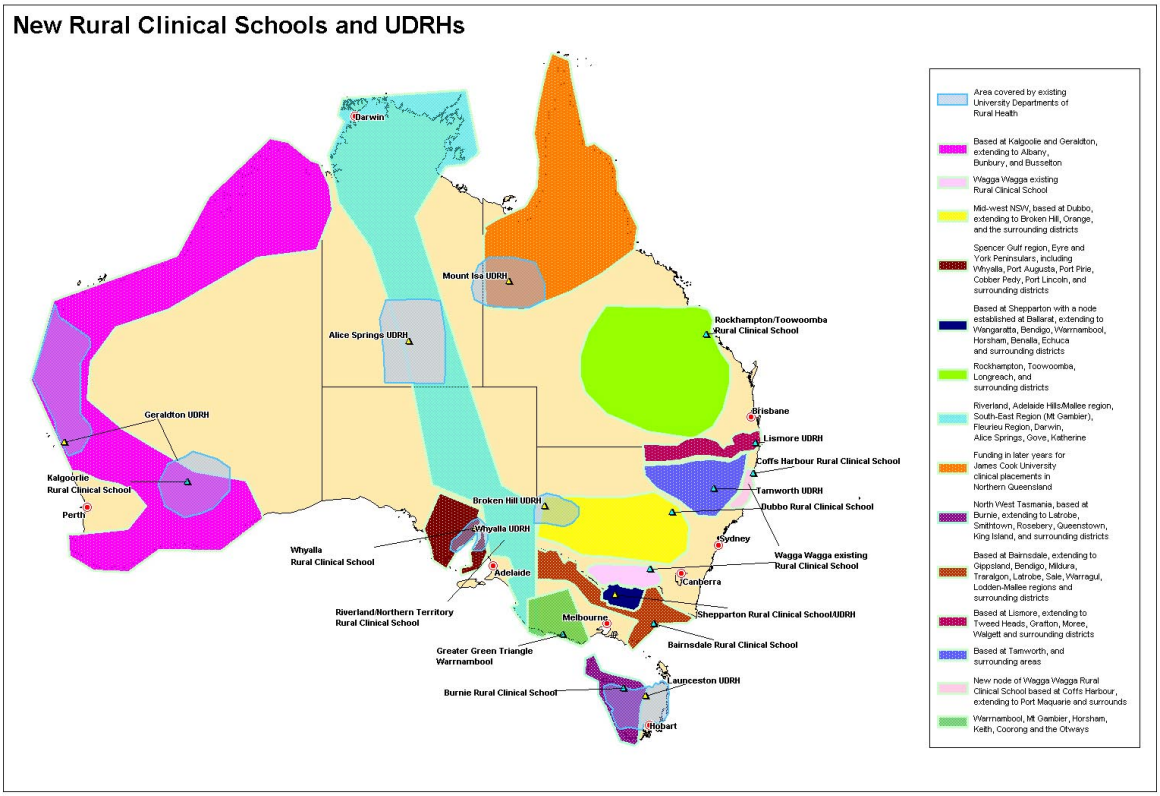
Hansard Page: CA 229

Senator West asked:

Provide a copy of the map that shows the locations of the New Rural Clinical Schools and University Departments of Rural Health.

Answer:

Attached is a copy of the map which broadly depicts the planned national network of education and training.


New Rural Clinical Schools and UDRHs
Darwin
Mount Isa UDRH
Alice Springs UDRH
Rockhampton/Toowoomba Rural Clinical School
Brisbane
Lismore UDRH
Coffs Harbour Rural Clinical School
Tamworth UDRH
Dubbo Rural Clinical School
Sydney
Wagga Wagga existing Rural Clinical School
Canberra
Shepparton Rural Clinical School/UDRH
Bairnsdale Rural Clinical School
Launceston UDRH
Hobart
Geraldton UDRH
Kalgoorlie Rural Clinical School
Perth
Broken Hill UDRH
Whyalla UDRH
Whyalla Rural Clinical School
Adelaide
Riverland/Northern Territory Rural Clinical School
Melbourne
Greater Green Triangle Warrnambool
Burnie Rural Clinical School
Area covered by existing University Departments of Rural Health
Based at Kalgoolie and Geraldton, extending to Albany, Bunbury, and Busselton
Wagga Wagga existing Rural Clinical School
Mid-west NSW, based at Dubbo, extending to Broken Hill, Orange, and the surrounding districts
Spencer Gulf region, Eyre and York Peninsulars, including Whyalla, Port Augusta, Port Pirie, Cobber Pedy, Port Lincoln, and surrounding districts
Based at Shepparton with a node established at Ballarat, extending to Wangaratta, Bendigo, Warrnambool, Horsham, Benalla, Echuca and surrounding districts
Rockhampton, Toowoomba, Longreach, and surrounding districts
Riverland, Adelaide Hills/Mallee region, South-East Region (Mt Gambier), Fleurieu Region, Darwin, Alice Springs, Gove, Katherine
Funding in later years for James Cook University clinical placements in Northern Queensland
North West Tasmania, based at Burnie, extending to Latrobe, Smithtown, Rosebery, Queenstown, King Island, and surrounding districts
Based at Bairnsdale, extending to Gippsland, Bendigo, Mildura, Traralgon, Latrobe, Sale, Warragul, Lodden-Mallee regions and surrounding districts
Based at Lismore, extending to Tweed Heads, Grafton, Moree, Walgett and surrounding districts
Based at Tamworth, and surrounding areas
New node of Wagga Wagga Rural Clinical School based at Coffs Harbour, extending to Port Maquarie and surrounds
Warrnambool, Mt Gambier, Horsham, Keith, Coorong and the Otways

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000097

OUTCOME 9: HEALTH INVESTMENT

Topic: CLINICAL SCHOOLS

Written Question on Notice

Senator Lees asked:

(a) What progress has been made on the funding of clinical schools in regional, rural and remote Australia? What funds have been committed and over what period to which schools?

(b) What outcomes are the Commonwealth expecting from this funding? What consultation has been undertaken with regional, rural and remote communities regarding the clinical schools?

(c) Have any special travel, accommodation or other arrangements been made for those studying at the clinical schools and will they apply to all students?

(d) How will local communities and specialists be engaged with the clinical schools in order to ensure both appropriate interaction and sensitivity to local communities and a high level of training and supervision?

Answer:

(a) Funding has been allocated this 2000-2001 financial year to assist medical schools to appoint Rural Clinical School coordinators, academic and support staff to facilitate developmental work of the Rural Clinical Schools for the next 12 months.

Simultaneous to the provision of interim funding, longer term contract negotiations for Rural Clinical Schools are continuing with relevant Universities. The Department expects to be in a position to sign long-term funding agreements with all universities establishing a Rural Clinical School by the end of this calendar year.

Below is a table indicating funding committed to individual universities, as of 19 June 2001, to facilitate developmental work this financial year.

Rural Clinical Schools – Progress (GST Exclusive)

UNIVERSITY	$
ADELAIDE	913,636
FLINDERS	250,000
MELBOURNE	400,000
MONASH	952,727
TASMANIA	454,545
NSW	500,000
QUEENSLAND	590,910
WESTERN AUSTRALIA	829,250
SYDNEY – CONTRACT YET TO BE NEGOTIATED	
TOTAL	4,891,068

(b) The Commonwealth's *Parameters for Funding Rural Clinical Schools* set the Government's objectives for the establishment of the Rural Clinical Schools. Funding is contingent upon the achievement of these Parameters (Attachment A).

The interim funding which has been provided will facilitate developmental work and extensive planning through the appointment of core and support staff, including Project managers, lecturers, and administrative support staff, to be located at the Rural Clinical School sites and surrounding regions, to meet the objectives of the Commonwealth's *Parameters*.

Negotiations regarding the progression of this initiative have included consultation with key local stakeholders throughout rural and regional areas in which Rural Clinical Schools will be located. Community participation is also facilitated through the establishment of local Community Advisory Boards for each Rural Clinical School. Community Advisory Boards comprise a broad range of representatives including local medical practitioners, area health services, state health authorities, local universities, local government, community and medical student representatives. The Community Advisory Boards will be chaired by the Commonwealth, and will build collaborative and strategic relationships whilst facilitating local partnership arrangements to benefit medical students and the local community, and ultimately the success of Rural Clinical Schools (Attachment B).

To date two Community Advisory Boards have held their first meetings. The Adelaide University Rural Clinical School Community Advisory Board met in Whyalla, South Australia, on 3 May 2001. The University of Tasmania North-West (Burnie) Rural Clinical School Community Advisory Board met in Burnie, Tasmania, on 13 June 2001. The Department is currently progressing the establishment of Community Advisory Boards for the remaining Rural Clinical Schools.

(c) Extensive negotiations with key stakeholders have indicated that accommodation and travel costs are issues which need to be addressed throughout the implementation of this initiative. The Department is presently actively looking into a range of possibilities to assist Rural Clinical Schools to address these needs.

(d) As per question (b).

PARAMETERS FOR FUNDING RURAL CLINICAL SCHOOLS

Through the *Government's Regional Health Strategy*, the Department of Health and Aged Care is providing funding to universities for the establishment of new clinical schools on a national basis to secure a rural education and training network which will increase the availability and viability of rural health services in the long term.

The establishment of rural clinical schools will focus on encouraging medical professionals to take up rural practice, provide education and training for medical students, as well as support for rural health professionals working in rural and remote areas.

Clinical schools, in conjunction with other rural focused initiatives including the establishment of University Departments of Rural Health (UDRH), will also facilitate research to be undertaken on rural issues, and facilitate greater collaboration and integration of service delivery in rural and regional areas.

This major health education initiative will also attract and inject significant capital infrastructure into those rural and regional areas in which clinical schools will be established, facilitating the provision and delivery of rural medical education equal to, and linked with respective urban university counterparts.

In working toward the achievement of these key priorities, it is essential that the new rural clinical schools are based on the following parameters:

1. By the commencement of the 2004 academic year 25% of medical students will undertake a minimum of 50% of their clinical years in a rural setting (RRMA 3-7).

2. The rural clinical school will provide students with experience across a range of specialist areas.

3. Academics appointed to the rural clinical school must live and work in the rural region.

4. No more than 15% of the budget may be utilised at the base university campus (capital city) in the first year, reducing to a maximum of 5% in 2004.

5. The university will participate on a local community advisory board, established by the Department of Health and Aged Care, to oversee the establishment of the clinical school. This board shall comprise a broad range of representatives, including local health professionals, area health services, state health authorities, the Commonwealth Dept Health & Aged Care, relevant local universities, local government and community representatives.

6. A full time resident clinical school coordinator will be appointed as a priority to facilitate the development of the clinical school at a grassroots level in the rural region.

7. The university will liaise closely with the Dept of Health and Aged Care regarding information technology and telecommunications issues, with telecommunications costs to be clearly identified within the budget.

8. The university will work collaboratively with the local community and state health department to maximise the utilisation of local facilities and expertise eg student accommodation, travel & IT resources. This collaboration will include partnerships with existing local tertiary institutions, for example, through mechanisms such as memorandums of understanding, to facilitate resource and information exchange.

9. The university will develop transparent internal evaluation mechanisms, remaining cognisant of external evaluating processes which may be implemented.

Question: E01000097

Attachment B

Terms of Reference for the Establishment of a Community Advisory Board

The function of each Community Advisory Board will be to build collaborative and strategic relationships for the Rural Clinical School.

The Board will facilitate local partnership arrangements whenever possible to ensure that existing and planned resources provide maximum benefits to both students and the local community.

More specifically, the Board will undertake the following:

1) Advise the Minister for Health and Aged Care, the Hon Dr Michael Wooldridge, on community issues relevant to the planning and implementation of the Rural Clinical School;

2) Provide a mechanism for involving the broader community to advance the planning and development of the Rural Clinical School;

3) Provide a mechanism for exchange of information to maximise the use of local facilities and expertise, including the utilisation of effective and efficient IT resources;

4) Provide a forum for exchange of information between the Department, the university and the local community;

5) Facilitate feedback, monitoring and evaluation of the rural clinical school's development and progress;

6) Provide a means for identifying and addressing barriers to successful implementation of the rural clinical school.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000088

OUTCOME 9: HEALTH INVESTMENT

Topic: BONDED SCHOLARSHIPS

Hansard Page: CA 227

Senator West asked:

What I want to know is what progress is going on. I want to know how many offers there have been. I want to know the number that have been accepted. I want to know the date that they have been paid their scholarship. I also want to know the date on which last year's recipients were paid their scholarships as well.

Answer:

The Medical Rural Bonded Scholarship Scheme was introduced in 2000, with the first cohort of 100 scholars being selected to start their medical course in 2001. The demand for places exceeded the number of available places. Universities have not yet provided data on the number of offers made and the proportion of acceptances.

All 100 places offered in the Medical Rural Bonded Scholarship Scheme have been filled, and payments for scholars commenced on 15 March 2001. Scholars are paid $20 000 per year in monthly instalments of $2000, paid on the 15th of each month from March to December. Each scholar will have been paid $8000 by 15 June 2001.

The distribution of places by medical schools is attached.

No Medical Rural Bonded Scholars were paid last year, as the scheme commenced with the 2001 academic year.

Medical Rural Bonded Scholarships Distribution of Places by University for the 2001 Intake

University	Distribution of Places
University of Sydney/ACT	15
Newcastle University	10
University of Tasmania	12
University of Adelaide	5
Flinders University of South Australia	10
University of NSW	5
University of Melbourne	10
Monash University*	0
University of Queensland	10
University of Western Australia	7
James Cook University	16
Total	100

* Monash University due to course restructure did not have a first year intake in 2001 but will be taking students from 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000091

OUTCOME 9: HEALTH INVESTMENT

Topic: 7:30 REPORT ON PREVENTING BIRTH OF HANDICAPPED INDIVIDUALS

Hansard Page: CA 233

Senator Harradine asked:

Will you take on notice examine whether or not a grant has been made in respect of an activity to someone who has a eugenics approach. I asked the NHMRC to examine the 7:30 Report. The article goes on to say: Professor Sutherland further angered disability advocates when he said he believed a visiting UK academic with dwarfism would prefer not to be handicapped.

Answer:

The context of the question refers to a grant from the National Health and Medical Research Council (NHMRC), identified as number 983210, to Professor Grant Sutherland at the University of Adelaide. The title of the grant is "Understanding the human genome: molecular mechanisms of genetic disease".

The NHMRC funds those research proposals that have the highest degree of scientific merit as determined by a rigorous system of peer review. This method of allocating funds is widely recognised as producing a broad base of research expertise and major advancements in health and medical knowledge. The National Health and Medical Research Council Act 1992 specifies that grants are to be provided in such cases and subject to such conditions as the Minister, acting on the advice of the Council, determines. Strong competition ensures that only the best applications are funded; the excellence of the research proposal and the record of achievement of the investigators are the main criteria for determining the allocation of funding.

Professor Grant Sutherland is a very distinguished Australian scientist. He heads the Department of Cytogenetics and Molecular Genetics at the Women's and Children's Hospital in Adelaide. He is a Fellow of the Australian Academy of Science and a Fellow of the Royal Society of London. Professor Sutherland's major contributions to science have been the cytogenetic and molecular genetic characterisation of fragile sites on human chromosomes. He is an active participant in the international Human Genome Project. His group has contributed significantly to the mapping of human chromosome 16 and positional cloning of genes on this chromosome. In clinical cytogenetics, he has many significant publications including a book on genetic counselling for chromosome abnormalities that has become the standard work in this area. He is a past-President of the Human Genetics Society of Australasia and is President of the Human Genome Organisation.

The NHMRC, as well as a number of other organisations, have supported Professor Sutherland's research. NHMRC support has been through a series of 'Program Grants': one (943210) entitled "Understanding the mechanisms of human inherited disease" provided funding of $1,921,479 over the period 1994 to 1997. Another (983210) entitled "Understanding the human genome molecular mechanisms of genetic disease" totals $4,959,145 over the period 1998 to 2002. Professor Sutherland was also awarded $40,000 towards the purchase of a Packard Instant Imager in 1996 (grant number 961436). Professor Sutherland has applied for a 'New Program Grant' to commence in 2002 - the application is titled "Understanding the Human Genome: Molecular Mechanisms of Genetic Disease". It is one of 38 applications proceeding to interview out of 75 received. There will be no double funding in 2002 if this application is successful.

In addition, an annual National Investigations Grant (942802) of $50,000 that forms Australia's contribution to the Human Genome Organisation is transferred to that organisation through Professor Sutherland.

The transcript of the 7:30 Report from 20 February 2001 has been examined. Views such as those expressed in the media by Professor Sutherland do not form part of the rigorous peer and scientific review of the research proposals submitted to the NHMRC. Grants to support research that are made by the NHMRC will continue to be awarded to researchers based on the competitive merit of their research proposals as judged by peer review.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000092

OUTCOME 9: HEALTH INVESTMENT

Topic: CONSISTENT LEGISLATION ON ASSISTED REPRODUCTIVE TECHNOLOGY

Hansard Page: CA 234

Senator Harradine asked:

The Prime Minister wrote to premiers and chief ministers suggesting that the issue of legislation on assisted reproductive technology be put on the COAG agenda for the June meeting. We will pursue with the Prime Minister's department to see if a copy of that letter can be made available to you (to Senator Harradine).

Answer:

A copy of the letter is attached.

PRIME MINISTER
CANBERRA

The Hon Jim Bacon MHA
Premier of Tasmania
GPO Box 123B
HOBART TAS 7001

My dear Premier

Further to my letter of 5 May 2001 confirming that the next meeting of the Council of Australian Governments (COAG) is to be held on 8 June, I propose to add a further item to the agenda on assisted reproductive technology, including human cloning.

I note that Health Ministers have previously agreed to ban human cloning but that legislation to this end is not yet in place in all states. I believe that the pace of scientific advances in this area warrants consideration by Heads of Government at this time. The Commonwealth will draft an agenda paper for this item to be circulated before the meeting.

I have written in similar terms to all Premiers and Chief Ministers and the President of the Australian Local Government Association.

Yours sincerely

Signed
25 MAY 2001

(John Howard)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGED CARE PORTFOLIO

Budget Estimates 2001-2002, 28/29 May 2001

Question: E01000093

OUTCOME 9: HEALTH INVESTMENT

Topic: STEM CELL RESEARCH

Hansard Page: CA 235

Senator Harradine asked:

On stem cell research, that is to say research dealing with stem cells derived from the manipulation of an adult cell of a patient where there are no ethical landmines, is there anything in the current grants that covers that particular issue?

Answer:

Currently there are nine research projects funded by NHMRC involved in dealing with human adult stem cells. The majority of these are related to bone marrow stem cells.