Community Affairs
Legislation Committee

Examination of Budget Estimates 2002-2003

Additional Information Received

VOLUME 3

Outcomes: whole of portfolio, 1 & 2

HEALTH AND AGEING PORTFOLIO

NOVEMBER 2002

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

ADDITIONAL INFORMATION RELATING TO THE EXAMINATION OF BUDGET EXPENDITURE FOR 2002-2003

Included in this volume are answers to written and oral questions taken on notice relating to the estimates hearings on 5 and 6 June 2002

HEALTH AND AGEING PORTFOLIO

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-024

OUTCOME: WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

(a) Is it true an officer in the Department of Health contacted an officer in Government Division of PM&C on 1 February 2002 for advice on a request by the former Minister for Health, Dr Wooldridge, for access to his e-mail records?
(b) Was this pursuant to a request from Dr Wooldridge for access to his e-mail records?
(c) If not, what was it pursuant to?
(d) If so, when did Dr Wooldridge make this request? To which section of the Department was it made?
(e) What exactly did Dr Wooldridge request?
(f) What advice did PM&C provide in response to this request? Did this advice make clear that access to e-mail records could only be provided under the scheme for special access for former ministers under the Archives Act?
(g) Was the PM&C advice conveyed to Dr Wooldridge? When was it conveyed? How was it conveyed? By whom?

Answer:

(a) An officer in the Department of Health and Ageing contacted the Department of the Prime Minister & Cabinet on 1 February 2002 and was provided with information on the provisions within the *Archives Act 1983* for former Ministers to have access to material they would have had when they were Ministers.

(b) Yes.

(c) See (b).

(d) Dr Wooldridge made this request on 29 January 2002. The request was made to a staff member in the Victorian Office of the Department.

(e) Dr Wooldridge referred to access to his email.

(f) The response from the Department of the Prime Minister and Cabinet is attached to the answer to question E02-026.

(g) The Department of the Prime Minister and Cabinet advice was not conveyed to Dr Wooldridge at the time. This was because senior officials in the Department did not know that Dr Wooldridge had ongoing access to his email records. However on 22 April 2002 Ms Mary Murnane, Deputy Secretary of Department of Health and Ageing sent the response to Dr Wooldridge by Fax. This was a response to a separate inquiry from Dr Wooldridge about the access rules that apply should he wish to refresh his memory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-025

OUTCOME: WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

(a) Dr Wooldridge has said (ABC AM 7 June) "my former department advises me they took advice from Prime Minister and Cabinet, and I was perfectly entitled to have access to what was on my own personal computer" and "I inquired and was told by a departmental officer that it was entirely proper." Is this correct?

(b) Dr Wooldridge has also said in the same interview: "I was given an undertaking by the department by a departmental officer that I would be given a week's notice before it was disconnected." Was such an undertaking given? If so, which section of the Department gave it? Was the departmental officer a former staffer of Dr Wooldridge?

Answer:

(a) The investigation has found no evidence that the Department sought advice from Department of the Prime Minister and Cabinet regarding Dr Wooldridge’s personal computer.

(b) The investigation found that a departmental liaison officer in Dr Wooldridge's former office informally undertook to try to give reasonable notice to Dr Wooldridge of any change to his access. The liaison officer was not a “former staffer” of Dr Wooldridge, that is, had never been employed under the *Members of Parliament (Staff) Act*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-026

OUTCOME: WHOLE OF PORTFOLIIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

If any or all of these communications (request/s from Dr Wooldridge to Dept of Health, request for advice from Dept of Health to PM&C, PM&C advice to Dept of Health, Dept of Health advice/s to Dr Wooldridge) were in writing, please provide copies to the Committee.

Answer:

The one written document in respect of the issues emanating from 29 January 2002 is attached.
[Note: the attachment has not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-027

OUTCOME: WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

(a) Did Dr Wooldridge have access to the departmental intranet at any stage after 27 November 2001?
(b) If so, what sort of material is available on the departmental intranet? Can the Internet be accessed through the departmental intranet?
(c) If so, did Dr Wooldridge access the Internet via the Department's intranet at any stage after 27 November 2001? What was the total time of such access? What was the cost?
(d) Can the Department determine how many documents, as opposed to emails were (i) accessed; and/or (ii) downloaded, by Dr Wooldridge after 27 November 2001?

Answer:

(a) Yes.

(b) The Departmental Intranet contains a large collection of information about the Department and its business for general use by staff. By way of example, the intranet contains information such as the Departmental structure, copies of Acts of Parliament, certified agreement information, chief executive instructions and procedural rules and the like. The internet can be accessed through the intranet.

(c) Yes. The total time cannot be measured. The use by Dr Wooldridge of the internet did not give rise to any extra cost to the Department.

(d) (i) There is no evidence that Dr Wooldridge has accessed any departmental records except for email. (ii) We cannot tell whether Dr Wooldridge used the internet to download documents.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-028

OUTCOME: WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

Was there any way in which Dr Wooldridge could have accessed current departmental documents through the intranet? Could departmental officials have sent current documents to him?

Answer:

Dr Wooldridge could have accessed information about the Department and its business through the intranet. By way of example, the intranet contains information such as the Departmental structure, copies of Acts of Parliament, certified agreement information, chief executive instructions and procedural rules and the like. Departmental officials could have sent current documents to Dr Wooldridge's email account with the Department, but none did so.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-029

OUTCOME:WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

Was the Ministerial email account to which Dr Wooldridge continued to have access until 13 March a BigPond account? If so, did Dr Wooldridge pay all the costs of his use of this account? How much was paid? When was it paid?

Answer:

The Department provided Dr Wooldridge with an account on its own network, and a separate BigPond account. Dr Wooldridge has reimbursed the Department for all the costs of providing the BigPond account. Dr Wooldridge paid $89.85 on 7 June 2002, and a further $406.23 on 27 June 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-030

OUTCOME:WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

Given the Minister ordered the first disconnection on 15 January the day Dr Wooldridge announced his appointment with the RACGP, was the Minister's attention drawn to Dr Wooldridge's continued access to the Departmental email system because of a perceived conflict of interest? If so, who drew the Minister's attention to this?

Answer:

The Minister’s attention was drawn to the matter of Dr Wooldridge’s access, as soon as an officer within her office became aware that Dr Wooldridge continued to have access.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-031

OUTCOME: WHOLE OF PORTFOLIO

Topic: DR WOOLDRIDGE: ACCESS TO EMAILS

Written Question on Notice

Senator Faulkner asked:

At any stage after 27 November, did Dr Wooldridge use his email account to order wine?

Answer:

There is no evidence that Dr Wooldridge used his Departmental email account to order wine after 27 November 2001.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-093

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator McLucas asked:

(a) What involvement did the Department have in the development of the Government's Intergenerational Report?
(b) When did Treasury first seek advice on this report?
(c) What sections of the Department have had input into the Intergenerational Report?

Answer:

The report was prepared by Treasury in consultation with relevant Departments. Consultations on modelling issues began with workshops in 2000. A Consultation Group specifically related to the Intergenerational Report was convened by Treasury in February 2002 and met several times. Informal consultation and discussion continued until the final draft of the report involving Departmental Officers from the Office for Older Australians, Aged and Community Care Division, Health Access and Financing Division, and Portfolio Strategies Division. Throughout the process, the Department had access to all materials relevant to health and aged care, provided data and other sources of technical or program information, and provided feedback on methodological issues, analyses, and the various drafts of the tables and text.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-094

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT (IGR)

Written Question on Notice

Senator McLucas asked:

(a) What involvement did the Department have in modelling health and ageing in the IGR?
(b) Did Treasury seek advice from the Department on the assumptions underpinning its health and ageing modelling?

Answer:

All modelling was undertaken by Treasury's Retirement Income Modelling Unit. The Department was involved in preliminary workshops regarding modelling issues and the underlying assumptions were discussed with the Department throughout the process.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-095

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator McLucas asked:

(a) How do assumptions underpinning the savings to the PBS outlined in the IGR differ from assumptions underpinning modelling of PBS savings in the Portfolio Budget Statements?
(b) What advice has the Department provided (since 1996) to Treasury on the growth of the PBS and other health care costs?

Answer:

(a) The estimates of PBS Budget savings were taken into account in the modelling of the PBS undertaken as part of the IGR.

(b) The Department regularly provides advice to the Department of Finance and Administration and Treasury concerning estimates of growth in PBS spending and other health programs as part of the ongoing process of updating its estimates of program expenditure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-096

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGERATIONAL REPORT

Written Question on Notice

Senator McLucas asked:

(a) What involvement did the Department have in the 1996 National Commission of Audit?
(b) How has or is the Department implementing the 1996 National Commission of Audit recommendations?

Answer:

(a) The Department provided a submission to the 1996 National Commission of Audit as did other major Departments.

(b) The Commission set out a mix of principles and broad recommendations for future directions. The Government did not formally endorse specific recommendations. Rather, the principles and recommendations have been used to inform policy development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-097

OUTCOME: WHOLE OF PORTFOLIO

Topic: . INTERGENERATIONAL REPORT

Written Question on Notice

Senator McLucas asked:

What role did the Department play in the preparations of the National Strategy for an Ageing Australia?

Answer:

The Department:

- chaired the Inter-Departmental Committee;
- drafted and published the six National Strategy Discussion Papers;
- advised the then Minister for Aged Care on the development of the National Strategy; and
- drafted and published the National Strategy for an Ageing Australia framework document.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-124

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

How was the Department involved in the development of the Intergenerational Report?

Answer:

Refer to Question E02-093

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-126

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

(a) At what stage did the Department/Minister see drafts of the Intergenerational Report
(b) Did the Minister for Health or the Minister for Ageing sign off on the Intergenerational Report

Answer:

(a) Refer to Question E02-093

(b) The Government, including the Minister for Health and Ageing, agreed to the release of the Intergenerational Report as part of the normal Budget process.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-127

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

(a) Was the Minister aware that the report would make claims that differed from his own and the Department's about the cost and the impact of an ageing Australian population?
(b) What action was taken to inform Treasury of the different views?

Answer:

As indicated in response to Question E02-093, the Department was involved in the drafting of the report. The Department is not aware of any fundamental differences about costs and impacts.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-129

OUTCOME: WHOLE OF GOVERNMENT

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

Overall what did the Aged and Community Care Division think of the Intergenerational Report?

Answer:

The Report is consistent with the National Strategy for an Ageing Australia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-130

OUTCOME: WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

(a) Was the Department surprised that there wasn't a single mention of the National Strategy for an Ageing Australia in the Intergenerational Report, nor was it referenced? Why does the Department think that was?
(b) How will the production of the Intergenerational Report impact on the National Strategy for an Ageing Australia?
(c) Why is the National Strategy for an Ageing Australia so much more optimistic about managing future needs than the Intergenerational Report?

Answer:

(a) The Intergenerational Report is a modelling of expenditure trends for government programs and is consistent with the issues covered by the National Strategy for an Ageing Australia.

(b) See (a).

(c) See (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-131

OUTCOME WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

(a) To what extent did the 1996 Audit inform the Intergenerational Report?
(b) How does the Department see the conclusions of the Intergenerational Report compared to those of the 1996 National Commission of Audit?

Answer:

(a) Treasury has indicated a wide range of sources as background to their thinking and to the development of their modelling approach including the National Commission of Audit. The Department is unaware of the extent to which the Audit informed their thinking.

(b) The conclusions of the two are consistent. However, the Intergenerational Report has benefited from the increasing body of research on the impacts of ageing that has been undertaken since the Audit, and from the accumulation of more recent data and experience.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-132

OUTCOME WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

(a) What role did the Department play in the preparation of Australia's response in 1999 to the OECD Questionnaire on progress towards implementing the recommendations of the 1998 OECD report 'Maintaining Prosperity in an Ageing Society'?
(b) How does the Department see the issues reported in this response compared to those raised by the Intergenerational Report?

Answer:

(a) The Department provided input to the Questionnaire in relation to health and aged care matters.

(b) The documents are broadly consistent. However, the Intergenerational Report has benefited from the increasing body of research on the impacts of ageing that has been undertaken since 1999, and from the accumulation of more recent data and experience.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-133

OUTCOME : WHOLE OF PORTFOLIO

Topic: INTERGENERATIONAL REPORT

Written Question on Notice

Senator Evans asked:

Has there been a request for work to be done from the Office of Older Australians for the next stage of the Intergenerational Report? If yes what?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-125

OUTCOME: WHOLE OF PORTFOLIO

Topic: RETIREMENT INCOME MODELLING UNIT

Written Question on Notice

Senator Evans asked:

(a) Did the Department ensure that the Retirement Income Modelling Unit was aware of the work of the National Strategy for an Ageing Australia? How was this done?
(b) Did the Department supply materials to the Retirement Income Modelling Unit? ie, copies of research they had commissioned?

Answer:

The Assistant Treasurer was a member of the Ministerial Reference Group which assisted in the development of the National Strategy for an Ageing Australia and hence had access to all papers associated with its development. The Retirement Income Modelling Unit was also involved throughout the process.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-220

OUTCOME: WHOLE OF PORTFOLIO

Topic: CONTACT FROM DR WOOLDRIDGE

Written Question on Notice

Senator McLucas asked:

In the Department's response to a question on notice from Additional Estimates 20th February 2002 (QON E02000020), the Department identifies a phone conversation from Dr Wooldridge requesting information 'where both Chiefs of Staff were advised'.

(a) What was requested and what advice did the Department provide?
(b) What other requests has Dr Wooldridge or anybody made on his behalf of the Department of Health and Aging since he retired from the Parliament? Please exclude from your answer the email and office access request discussed with Senator Faulkner during the estimates hearings, and the aged care briefing outlined in answer to QON E0200020.
(c) How were these requests made (in meetings, by phone, by written requests etc.)?
(d) What was requested and what information did the Department provide?
(e) Please provide a chronology of requests and Departmental responses

Answer:

(a)

Information requested	**Information provided**
Basic aged care planning data for the Southern Metropolitan region in Victoria	The information provided, which is in the public domain, was that the Southern region was on target against the planning ratios and that it was not possible to foreshadow what might be available in future ACAR rounds.

(b-e) See attached table

Chronology of Requests and Departmental Responses

Date of Request	How request was made? (meeting, phone, written requests etc)	What was requested?	What information was provided?
5 December 2001	Email	Whether it would be possible to transfer the Ministerial office (Glen Iris) telephone number through to Dr Wooldridge's home telephone number (by redirecting the line for 3 months).	Advice that a redirection of lines was not possible. Department requested disconnection of the line on 11 December 2001.
Early December 2001	Telephone	Organisation of a removalist to remove personal ministerial items from the Glen Iris Ministerial Office.	Advice that the company booked to remove the Departmental assets from the Glen Iris Office would also transfer personal items to the removalist's warehouse, where they could be collected.
26 February 2002	Telephone	Phone number for the head of the Thai Population and Community Development Association	A phone number
1 March 2002 answered on 4 March 2002 **(same request as in part a)**	Telephone	Basic aged care planning data for the Southern Metropolitan region in Victoria	The information provided, which is in the public domain, was that the Southern region was on target against the planning ratios and that it was not possible to foreshadow what might be available in future ACAR rounds.
Around 10-15 April 2002	Telephone	Whether, as a former Minister, he would have access to material he would have had while Minister. Documents on Private Health Insurance, including Lifetime Cover, were mentioned by him.	Advice that under certain conditions, subject to the Archives Act, former ministers do have access to material that they would have had when they were ministers. Relevant information from the Archives Act, including a legal interpretation and advice on how to activate a request for information was faxed to Dr Wooldridge on 22 April 2002. A formal request for the information did not eventuate.
14 April 2002	Telephone	Details of vehicle/car hire costs from 1 July to 31 December 2001 in response to DoFA's six monthly tabling requirements.	Provision of the relevant breakdown of costs
Late April 2002	Email	A meeting was requested between the Monash (University) Institute for Health Services Research (MISHR), the RACGP (Dr Wooldridge) and the TGA to discuss education of GPs about complementary	The meeting was held on 9 May 2002 and discussion was around the regulatory system for complementary medicines.

Date of Request	How request was made? (meeting, phone, written requests etc)	What was requested?	What information was provided?
		medicine	
Week commencing 13 May 2002	Telephone	Requested information on any outstanding accounts (mobile, Bigpond etc) that was owing to the Department. Also requested the originals of itemised phone accounts.	Letters detailing items yet to be paid were forwarded to Dr Wooldridge. In addition, original itemised phone accounts were provided.
29 May 2002	Telephone	Further advice on reimbursement in respect of phone and Big Pond accounts and purchase of a fax machine. Sought confirmation that all personal issue assets had been returned.	Invoices for appropriate amounts. Confirmation that all known assets had been returned with the exception of a fax machine, pending Dr Wooldridge's decision on purchase. Purchase did not proceed and fax was returned.
13 June 2002 Answered on 14 June 2002	Telephone	Confirmation of his recollection that a Departmental officer had requested a copy of a particular report from the AMA.	Confirmation that a departmental officer expressed interest (on several occasions) in receiving a copy of the report but the AMA had failed to provide a copy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-214

OUTCOME: WHOLE OF PORTFOLIO

Topic: ELECTORATE PROFILES

Hansard Page: CA371

Senator McLucas asked:

Yesterday, we were talking about the electorate profiles that were on the website. I think someone said that they had been on the web site only once. I do not know whether that is correct?

Answer:

The Electorate Profile Series was published on the Department's website on only one occasion - when the June 2000 edition was published in PDF format.

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-216

OUTCOME: WHOLE OF PORTFOLIO

Topic: PUBLIC AFFAIRS – STAFFING NUMBERS

Written Question on Notice.

Senator McLucas asked:

Can the Department please provide the number of staff it has employed in public affairs, marketing and advertising positions for the past five financial years? What are the budget numbers for 2002-03 years?

Answer:

The Department is unable to provide detailed information of staffing numbers employed in these activities over the past five years due to changes to the computer reporting mechanisms and does not have sufficient resources to produce this information manually.

The Department can provide an average number of public affairs and marketing staff for the financial year 2001-2002, which was 42.5.

The budget staffing numbers for 2002-2003 provides for up to 42.5 staff to be employed in positions involving public affairs, marketing and adverting.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-217

OUTCOME: WHOLE OF PORTFOLIO

Topic: MARKETING AND PROMOTION

Written Question on Notice

Senator McLucas asked:

(a) What marketing / promotion / information / advertising campaigns did the Department run in the financial year 2000-2001 and 2001-2002. Please provide a list of these campaigns and their target audiences:
(b) What was the total expenditure for each campaign?
(c) Please break expenditure down into Departmental and other expenditure for each of these campaigns
(d) Please provide a list of consultancies associated with these campaigns clearly stating which campaign each consultant was involved with and the cost of these consultancies.

Answer:

(a-b) See attached table.

(c) All campaigns and activities were financed from administered funding. There are two exceptions to this statement:
- The IME activity was financed from Departmental funding; and
- The Regional Health Strategy – Communication, 2001-2002 was also financed from Departmental funding.

(d) See attached table.

CAMPAIGN	**TARGET AUDIENCE**	**TOTAL EXPENDITURE**		**CONSULTANCIES**	
		2000/01	**2001/02**	**Name**	**Cost (over 2 years)**
The Private Health Insurance (PHI) Gaps Communication Campaign 2001-2002	Primary: • All Australians with PHI. In particular, higher end users of the system such as people who are chronically ill, older people, young families. • Australians without PHI Secondary: • Private Health insurance funds, the Australian Medical Profession	$10,120,710	$1,217,723	Turnbull Porter Novelli (now Porter Novelli) Whybin TBWA Quantam Market Research	$270,468 $1,508,934 $473,982
Asthma 3+ Visit Plan 2001-2002	General practitioners	Nil	$245,420	Newton, Wayman and Chong Luminis Pty Ltd National Asthma Council	$55,670 $134,750 $55,000
PBS Federal Budget Announcement 2001-2002	Consumers: • Concession card holders, general public Health Professionals/Service Providers: • Pharmacists, doctors, peak bodies	Nil	$226,450	N/A	N/A
Improved Monitoring of Entitlements (IME) 2001-2002	Dispensers: • Community pharmacists, hospital pharmacists, pharmacy staff, peak bodies Prescribers: • General Practitioners, specialists, hospital doctors Consumers – Primary: • High users of prescription medications • Low users of medication who have little contact with prescribers or dispensers • Family / informal carers • Consumer representative groups • Indigenous Australians Consumers – Secondary: • Marginalised consumers, such as the homeless (who are moving between institutions and accommodation, such as hostels in community settings and are likely to be without Medicare cards) • Community influencers (eg. MPs and Senators, notable commentators) • Peak groups representing marginalised consumer groups • Visitors from countries with Reciprocal Health Care Agreements • the media Special audiences: • Specific strategies and materials were developed for consumers from Culturally and Linguistically Diverse backgrounds (CaLD) and	$449,961	$1,886,495	RTM Graphic Design Wendy Bloom & Associates Developmental research Hill & Knowlton Pty Ltd Bates Healthworld Wendy Bloom & Associates Concept testing Wendy Bloom & Associates Indigenous-developmental and concept testing Wendy Bloom & Associates GP concept testing Wendy Bloom & Associates Benchmark research Wendy Bloom & Associates Additional concept testing Wendy Bloom & Associates	$3,390 $81,374 $86,933 $237,940 $49,767 $55,467 $12,540 $2,676 $6,264 $8,413

CAMPAIGN	**TARGET AUDIENCE**	**TOTAL EXPENDITURE**		**CONSULTANCIES**	
		2000/01	**2001/02**	**Name**	**Cost (over 2 years)**
	Indigenous Australians.			Tracking research	
The Regional Health Strategy – Communications 2000-2001/2001-2002	Health professionals, students, rural and regional communities and the general community	[1]$913,425	$1,113,249	Research Advantage Albert Research Colmar Brunton	$21,762 $52,747 $222,846
National Alcohol Campaign 2000-2001/2001-2002	Primary: • 15-17 year olds Secondary: • a) 18-24 year olds and b) parents of 12-17 year olds	$2,161,121	$2,528,364	Batey Kazoo Communications Quay Connection NCS A'asia Pty Ltd (Tracking Research) Elliott & Shanahan Research (Pre-testing) Newspoll (Parent Tracking)	$506,318 $192,287 $153,409 $59,124 $14,387
BreastScreen Australia	Women aged 50-69 years	$1,825,497	$303,262	DDB Needham Advertising Turnbull Porter Novelli University of Melbourne Centre for Womens' Health (Data Review) Woolcott Research (Benchmark) Woolcott Research (Tracking)	$78,595 $73,951 $17,511 $84,000 $88,000
National Cervical Cancer Screening Campaign 2000-2001/2001-2002	Women 18-70 years	$188,133	$587,461	Oddfellows Advertising Wendy Bloom and Associates (Concept Research)	$204,462 $63,296
National Illicit Drugs Campaign 2000-2001/2001-2002	Parents of 8-17 year olds	$13,115,827	$646,120	Batey Kazoo Communications –	$2,817,489

[1] The Regional Health Strategy's total expenditure over 4 years is $4 million.

CAMPAIGN	**TARGET AUDIENCE**	**TOTAL EXPENDITURE**		**CONSULTANCIES**	
		2000/01	**2001/02**	**Name**	**Cost (over 2 years)**
				Stancombe Research (Concept Testing) - Wallis Consulting (Eval'n Rsch) – AC Neilsen (Audit of Booklet delivery) Quay Connection T&L Advertising (NESB) State and Territory Drug Info Services	$162,165 $397,753 $71,160 $278,318 $442,750 $72,426
National Tobacco Campaign 2000-2001/2001-2002	Smokers 16-40 years old	$2,700,000	$2,800,000	Roy Morgan Research Pty Ltd Wallis Consulting Group Woolcott Research (Eval'n) Brown Melhuish and Fishlock (Adv'g) Quay Connection (PR) Public Relations Wallis Consulting Group (Eval'n)	$191,000 $41,688 $66,500 $402,191 $262,905 $19,653
Alcohol (Rock Eisteddfod TV Specials)	Young people aged 15 – 17 years.	$531,761	$528,000	Wallis Consulting Group Quay Connection	$53,705 $24,576
Croc Festival Sponsorship	Young Indigenous students, aged 8 – 18, in remote and rural Australia	$199,664	$573,485	Australian Curriculum Studies Association	$23,728
Commonwealth Carelink Campaign 2000-2001/2001-2002	Primary: • Potential consumers including older Australians, younger people with disabilities, their carers, with a focus on those living within areas where Commonwealth Carelink Centre shopfronts will be established;	$1,108,134	$312,312	NFO Donovan Research	$10,487

CAMPAIGN	**TARGET AUDIENCE**	**TOTAL EXPENDITURE**		**CONSULTANCIES**	
		2000/01	**2001/02**	**Name**	**Cost (over 2 years)**
	• Service providers, who offer the services to which Commonwealth Carelink Centres will direct consumers; • Referrers, who will use Commonwealth Carelink Centres to refer clients, including general practitioners, Divisions of General Practice and other health professionals. Secondary: • Influencers:- those who might influence consumers, referrers and service providers such as representatives of professional groups, stakeholders eg: nursing associations, GP peak groups, residential care peak bodies such as Council on the Ageing, Aged and Community Services Australia, other consumer and industry bodies, consumers and those who influence consumers eg: MPs, family, friends, carers, consumer groups, community service organisations; and • Communities in which Commonwealth Carelink Centre shopfronts will operate				
Minister's Awards for Excellence in Residential Aged Care 2000-2001/2001-2002	Aged Care Industry	$85,000	$56,479	N/A	N/A

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-218

OUTCOME: WHOLE OF PORTFOLIO

Topic: MARKETING CAMPAIGNS PLANNED FOR 2002-2003

Written Question on Notice

Senator McLucas asked:

(a) What marketing/promotion/information/advertising campaigns are planned for the 2002-03 financial year?
(b) Can you provide an estimated budget for each?

Answer:

CAMPAIGN	ESTIMATED BUDGET
The third year of the four-year Regional Health Strategy, communication strategy.	$1 million
Ongoing implementation of the Health*Insite* communication strategy.	$120,000
Ongoing communication activities for the Asthma communication strategy.	$200,000
Ongoing communication activities for consumers for diabetes awareness within National Integrated Diabetes Program.	$2 million
Implementation of the *Better outcomes in mental health care* initiative communication strategy.	$200,000
Implementation of the BMMS Field Test communication strategy	Budget yet to be determined
Beginning implementation of the PBS communication strategy.	$6.75 million
Changes to Pathology Services Funding Phase 2 Information Material	$159,000
Ongoing implementation of the HealthConnect communications strategy	$200,000
Ongoing implementation of the Commonwealth Carelink Communication Strategy	$400,000
Ongoing implementation of the Communication/Information product for Quality Aged Care	$1.5 million
Ongoing implementation of the Continence Management Communication Strategy	$1 million
Implementation of the NHMRC communications strategy	$300,000
National Indigenous Pneumococcal and Influenza Immunisation Program	$39,600
National Childhood Pneumococcal and Immunisation Program	$39,600
National Alcohol Campaign	$1.8 million
Breastscreen Australia	$375,000
National Cervical Screening Campaign	$210,000
National Illicit Drugs Campaign	$9.6 million
National Tobacco Campaign	$2.3 million

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-219

OUTCOME: WHOLE OF PORTFOLIO

Topic: MARKETING/PROMOTION - PBS

Written Question on Notice

Senator McLucas asked:

(a) Is the Department developing a specific marketing/promotion/information campaign for the PBS
(b) How many staff are involved in the PBS campaign
(c) What is the budget for the PBS campaign
(d) What themes have been developed for any PBS campaign

Answer:

(a) Yes

(b) The Communication Strategy still needs approval from the Ministerial Committee on Government Communication and staff required to work on the campaign cannot be confirmed until level of campaign activity is agreed.

(c) $6.75 million each year for four years

(d) To raise awareness improve and understanding of entitlements under the PBS.

Note: Only page 1 of 10 pages has been included in this volume.

TABLED BY DoHA 5/6/02

AUSTRALIAN GOVERNMENT SOLICITOR

Our ref: 02049154

31 May 2002

MORNING-AFTER PILLS

OPINION

1. We are asked by the Department of Health and Ageing (DHA) to review 1997 advice by the Attorney-General's Department to the effect that morning-after pills are not abortifacients. The review is sought in the light of an opinion by Brian Donovan QC and a recent UK decision of Munby J (unreported, 18 April 2002).

2. Our conclusion is that an Australian court is likely to follow the recent UK decision and find that morning-after pills are not abortifacients. Therefore, the conclusion in the 1997 advice remains correct.

Background

3. The *Therapeutic Goods Act 1989* (the Act) contains a number of provisions concerning 'restricted goods'. 'Restricted goods' are defined in s.3(1) of the Act to mean 'medicines (including progesterone antagonists and vaccines against human chorionic gonadotrophin) intended for use in women as abortifacients'. Accordingly, it is necessary for the purposes of administering the Act to decide from time to time whether certain products are abortifacients.

Chief General Counsel

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-053

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TOUGH ON DRUGS - HEROIN DEPENDENCY

Written Question on Notice

Senator Denman asked:

(a) What proportion of heroin dependent Australians are currently estimated to be receiving some form of drug treatment?
(b) What proportion of heroin dependent Australians were estimated to be receiving some form of drug treatment each year since the commencement of 'Tough on Drugs'.

Answer:

(a) It is not possible to answer this question directly as this information is not collected in one data collection process. The most recent estimation of the number of dependent opioid users in Australia was undertaken by the National Drug and Alcohol Research Centre in 2000. This study estimated the total number of opioid users to be between 67,000 and 92,000.

The Clients of Treatment Service Agencies (COTSA) study, conducted in 2001, which describes the characteristics of clients attending drug and alcohol treatment services on one day of the year, estimated that 32 percent of clients presented with opiates as their principal drug problem. This figure does not include clients who are being treated solely through methadone maintenance therapy. Question E02-067 provides information about the current number of clients on a methadone program.

(b) Information of this type is not currently collected by the Department.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-054

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: MEDICAL USE OF CANNABIS

Written Question on Notice

Senator Denman asked:

Will the Commonwealth Government allow States which wish to permit medicinal use of cannabis for selected patients with terminal illness and distressing symptoms unrelieved by conventional treatments?

Answer:

The laws governing the possession and use of cannabis primarily remain the responsibility of state and territory governments.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001-2002, 5 & 6 June 2002

Question: E02-055

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: DRUG OVERDOSE DEATHS

Written Question on Notice

Senator Denman asked:

The number of drug overdose deaths in Australia increased from 6 in 1964 to 958 in 1999 and then declined to 725 in 2000 (with a likely further drop in 2001 although these figures are not yet available). Does the Australian Government have any goal or target or any plan for further educations in these tragic deaths of young Australians?

Answer:

The National Heroin Overdose Strategy, adopted by the Commonwealth and State and Territory Governments through the Ministerial Council on Drug Strategy, provides nationally agreed priorities for reducing the incidence of heroin related overdose in Australia and for reducing morbidity and mortality where overdose does occur. It provides examples of strategies to address each of the priorities. The Strategy provides a nationally consistent focus for determining resourcing priorities and also the flexibility to allow jurisdictions to pursue strategies appropriate to their particular circumstances.

The Strategy aims to reduce the incidence of fatal and non-fatal overdoses by:

- increasing the number of drug users entering and remaining in drug treatment;
- assisting drug users to reduce their risk of overdose and increasing awareness regarding the consequences of overdose;
- improving the evidence base to inform strategies and programs to reduce overdose; and
- increasing the timeliness and reliability of data in respect to overdose.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-056

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: CONTROL OF HEPATITIS C

Written Question on Notice

Senator Denman asked:

The National Centre in HIV Epidemiology and Clinical Research completed a report for the Australian National Council on HIV, Hepatitis C and Related Diseases which estimated that the number of new hepatitis C infection in Australia increased from 11,000 in 1997 to 16,000 in 2001. How does the Australian Government propose to gain control of the hepatitis C epidemic given the increase in new infections during the period when Drug policy has been ' Tough on Drugs'.

Answer:

The Hepatitis C Virus Projections Working Group of the Australian National Council on AIDS, Hepatitis C and Related Diseases (ANCAHRD) has recently completed a project on *Estimates and Projections of the Hepatitis C Epidemic in Australia.* This document is currently undergoing ANCAHRD approval processes. The anticipated release date of the report is July 2002.

The report updates and refines the estimates and projections from the previous Working Group report in 1998. The findings are estimates and projections of hepatitis C incidence and prevalence in Australia over the period 1997-2001.

The Annual Surveillance Report 2001 (National Centre for HIV Epidemiology and Clinical Research) identifies hepatitis C as the most frequently reported notifiable infection in Australia. The number of cases of hepatitis C reported in 2000 was 20,926. However, the number of notifications over the period 1996-2000 has remained at approximately 18,000-22,000 per year.

Understanding of the hepatitis C epidemic has improved greatly in the last decade. However, knowledge about hepatitis C remains incomplete. The Government will continue to pursue research and surveillance in order to improve the evidence base for the development of public policy programs. The focus of this work will be in a collaborative, non-partisan manner with governments at all levels; medical, scientific and healthcare professionals; and with people affected by hepatitis C.

The Government will continue to implement the *National Hepatitis C Strategy 1999-2000 to 2003-2004*. The Strategy provides a five-year framework for strategic directions and coordinated action to address hepatitis C in Australia. The Strategy has two primary aims, namely to reduce the transmission of hepatitis C in Australia, and to minimise the personal and social impacts of hepatitis C infection. The Strategy is based on six essential components which are considered fundamental to developing effective responses. These components are developing partnerships and involving affected communities; access and equity; harm reduction; health promotion; research and surveillance; and linked strategies and infrastructures.

In addition, the Government is currently undertaking a Review of the Strategy that will be completed by late 2002. The outcome of this Review will be recommendations to me (Patterson) which will inform the future direction of the response to hepatitis C.

The prevention of high-risk behaviours such as injecting drug use has been an important component of the aims of the Strategy and is likely to remain so. As a result, links and opportunities for joint efforts will continue to be explored with the *National Drug Strategic Framework 1998-99 to 2002-2003*, to ensure that health promotion messages are well coordinated.

The Government does not condone illegal risk behaviours such as injecting drug use, but it does acknowledge that these behaviours occur. Accordingly, the Government will pursue measures to improve the health, social and economic outcomes for both the community and the individual, including harm reduction strategies such as Needle and Syringe Programs (NSPs).

Notwithstanding the apparent increase in hepatitis C infection in Australia, there is evidence that NSPs have an important role to play in preventing the transmission of bloodborne viruses. It has been found, for example, that that hepatitis C prevalence among people who inject drugs declined from 63 per cent to 50 per cent in the period 1995-1997. Recent findings indicate that, through the introduction of NSPs, 21,000 hepatitis C infections have been prevented.

The Government will continue to implement harm reduction measures in conjunction with supply-reduction strategies to disrupt the production and supply of illicit drugs, and demand-reduction strategies designed to prevent the uptake of harmful drug use. Through measures such as those outlined above, and through increasing understanding of the hepatitis C virus, the Government will continue to meet its responsibility to develop and implement public health measures to address bloodborne viruses such as hepatitis C.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-072

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TOUGH ON DRUGS

Written Question on Notice

Senator Denman asked:

(a) What was the evidence that was used as a basis for introducing the Tough on Drugs Strategy?
(b) What were the objectives for each of the elements of the Tough on Drugs Strategy?
(c) Which, if any, of those objectives have been evaluated? What was the evaluation criteria and what was the outcome?
(d) Has the expenditure of the funds on the Tough on Drugs Strategy been shown to be effective?

Answer:

(a) The National Drug Strategic Framework 1998-99 to 2002-04 maintains the policy principles of the previous phases of the National Drug Strategy and adopts the recommendations of The National Drug Strategy: *Mapping the Future: An evaluation of the National Drug Strategy 1993-97 (Single & Rohl 1997).* To demonstrate the Government's commitment to the fight against the use of illicit drugs, the Prime Minister launched the National Illicit Drug Strategy "*Tough on Drugs*" in November 1997. The Council of Australian Governments (COAG) supported the National Illicit Drug Strategy as the next major phase of the National Drug Strategy.

(b) The overarching aim of the National Illicit Drug Strategy is to reduce the health, social and economic consequences of illicit drug use on Australian society. It encompasses a balanced package of measures aimed at law enforcement, education, treatment and research.

(c) Evaluations of the major components of the National Illicit Drugs Strategy are detailed below:

- The COAG Illicit Drug Diversion Initiative and Supporting Measures was announced by the Government in the 1999-2000 Federal Budget. The Department of Finance and Administration are currently overseeing the evaluation of the Initiative, with the final evaluation report due in October 2002.
- The National Drug Research Institute (Curtin University) has been commissioned to evaluate the Community Partnerships Initiative, and this evaluation will be completed in early 2003.

- The Terms of Reference for the evaluation of services funded under the Non-Government Organisations Treatment Grants Program (NGOTGP) will be provided to an expert committee once they are available (see answer to question E02-078). It is anticipated that the evaluation of the NGOTGP will commence in 2003 and be completed in 2005-2006.
- The first phase of the National Illicit Drugs Campaign, which focused on parents, has been evaluated using information from nine different research projects covering developmental, benchmark and tracking research, followed by post-campaign evaluation of mainstream and non-English language activities. In summary, the evaluation found:

    - 97% of parents, 97% of young people, 96% of community members and 86% of parents from non-English speaking backgrounds recognised at least one element of the campaign.
    - half of all parents surveyed said that the campaign prompted them into action.
    - parents said the campaign increased their knowledge about drugs and helped them talk about drugs to their children.

(d) Yes. The latest research suggests that since the introduction of the National Illicit Drug Strategy there have been a number of achievements which include: fewer people using illicit drugs; an unprecedented increase in drug seizures; fewer heroin overdose deaths; more parents talking to their children about drugs; more treatment services being provided to drug users; and new treatment options available for drug users.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-075

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TOUGH ON DRUGS

Written Question on Notice

Senator Denman asked:

(e) What proportion of the total allocations to drugs by the Commonwealth government – outside the Tough on Drugs program – has been allocated to law enforcement, treatment, prevention and research?
(f) Of the allocation to drug treatment, what proportion has gone to abstinence based programs?
(g) Do you have at your fingertips what proportion has gone to public health evidence based programs, such as the pharmacological treatment programs?
(h) How much of the treatment money was given to the Salvation Army?

Answer:

(a) Complete information on these issues is not available.

(b) Under the National Illicit Drug Strategy the Commonwealth has allocated $57 million to 133 non government organisations through the Non-Government Organisation Treatment Grants Program to provide a range of drug treatment services nationally. Treatment activities funded cover a range of strategies including brief interventions, self help programs, psychological therapies, outreach support, outpatient counselling, inpatient and outpatient detoxification, medium to long term rehabilitation counselling, social skills training and relapse prevention.

(c) The Commonwealth covers the wholesale cost of methadone syrup under Section 100 of the Pharmaceutical Benefits Scheme. In 2000/01 $3,396 million was spent on methadone.

(d) Under the National Illicit Drug Strategy Non-Government Organisation Treatment Grants Program a total of $5.4 million has been allocated for 15 projects to the Salvation Army for a range of drug treatment services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-058

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TOUGH ON DRUGS – NUMBER OF DEATHS

Written Question on Notice

Senator Denman asked:

Does the Government have any estimate of the number of deaths, HIV infections, hepatitis C infections, or crimes that have been prevented by pharmacological treatments of heroin dependent persons since the commencement of the 'Tough on Drugs' program?

Answer:

It is not possible to estimate the number of deaths, or the number of HIV and hepatitis C infections that have been prevented specifically through pharmacological treatment of heroin dependent persons because:

- the prevention of harm is achieved through a range of strategies targeted at particular population groups;
- evidence suggests that many drugs, licit and illicit, are used in combination.

A report presented to the Ministerial Council on Drug Strategy in July 2001, on the National Evaluation for Pharmacotherapies for Opioid Dependence project, conducted by the National Drug and Alcohol Research Centre, found that: at baseline heroin users reported involvement in property crime (20%), drug dealing (23%), fraud (8%) and violent crime (3%) in the previous month. In contrast, for patients who were in treatment at three/six months, reductions were apparent for property crime (10% and 7% respectively), drug dealing (13% and 14% respectively), fraud (5% and 7% respectively) and violent crime (2% at both periods).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-059

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TOUGH ON DRUGS - EFFECTIVENESS

Written Question on Notice

Senator Denman asked:

(a) How many and which ones of the categories or subprograms (ie. Diversion programs, abstinence treatment programs etc) have been evaluated and what are the outcomes of those evaluations?
(b) In those evaluations which ones have been effective in reducing drug use or preventing drug use or delaying the uptake of drug use?
(c) If there are any in this category what is the plan for ongoing or future funding?
(d) What are the plans for those that have not been evaluated or have not been shown by evaluation to be effective?

Answer:

(a-b) Evaluations of the major components of the National Illicit Drugs Strategy are detailed below:

- The COAG Illicit Drug Diversion Initiative and Supporting Measures was announced by the Government in the 1999-2000 Federal Budget. The Department of Finance and Administration are currently overseeing the evaluation of the Initiative, with the final evaluation report due in October 2002.
- The National Drug Research Institute (Curtin University) has been commissioned to evaluate the Community Partnerships Initiative, and this evaluation will be completed in early 2003.
- The Terms of Reference for the evaluation of services funded under the Non-Government Organisations Treatment Grants Program (NGOTGP) will be provided to an expert committee once they are available (see answer to question E02-078). It is anticipated that the evaluation of the NGOTGP will commence in 2003 and be completed in 2005-2006.
- The first phase of the National Illicit Drugs Campaign, which focused on parents, has been evaluated using information from nine different research projects covering developmental, benchmark and tracking research, followed by post-campaign evaluation of mainstream and non-English language activities. In summary, the evaluation found:

    - 97% of parents, 97% of young people, 96% of community members and 86% of

parents from non-English speaking backgrounds recognised at least one element of the campaign.
- half of all parents surveyed said that the campaign prompted them into action.
- parents said the campaign increased their knowledge about drugs and helped them talk about drugs to their children.

(c) The outcomes of the evaluations will inform on-going and future funding decisions in relation to the National Illicit Drug Strategy.

(d) All other projects funded under the National Illicit Drug Strategy have an evaluation component as part of their associated contractual arrangements.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001-2002, 5 & 6 June 2002

Question: E02-060

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS CAMPAIGN – TOUGH ON DRUGS HOUSEHOLD BOOKLET

Written Question on Notice

Senator Denman asked:

(a) How much was expended on the household booklet that was recently sent to all households?
(b) What has been the effectiveness of that program?
(c) How many or what proportion of people have reduced, delayed or have been prevented from using drugs as a result of that campaign?

Answer:

(a) The costs associated with the parents booklet are as follows:

- paper, storage of paper, and printing (8.5 million booklets)	$2,309,460
- plastic wrapping	$551,387
- freight for wrapped booklets	$83,685
- artwork and photography	$64,000
Subtotal production and printing	**$3,008,532**
- distribution	($701,995.18) (contractual) $612,139.80 (actual)
- NESB translation and printing (200,000 booklets)	$254,333
- Audit (part of T&L contract)	$71,000
- **Total**	**$3,946,004.80**

(approximately 46 cents per booklet)

(b) Part One of the NIDC was launched on 25 March 2001, targeting parents of 8-17 year olds to give them information to help them talk to their children about illicit drugs. The campaign provided information and support to parents and carers on the positive role they can play in preventing drug use amongst children. The aim was to enhance parents' and carers' skills in communicating with children about illicit drugs in order to deter the initiation or continuation of drug use by children.

The Campaign's evaluation report includes nine different research projects covering developmental research, benchmark surveys, tracking research, post-campaign evaluation surveys and NESB evaluation research. Results from the post-campaign evaluation surveys indicate that the campaign has been effective in reaching its primary and secondary target audiences and encouraging these audiences to engage in discussions with their children and each other about illegal drugs.

In summary the evaluation found:

- Ninety-seven per cent of parents recognised at least one element of the campaign
- Recognition was also extremely high amongst youth (97%), community members (96%) and parents from a non-English speaking background (86%).
- Three in five parents (58%) felt that the campaign as a whole had made it easier to talk to their child about illegal drugs. This was because the campaign assisted to facilitate discussion and because parents reported having greater knowledge on the subject.
- One in two youth (49%) stated that the campaign had made it easier to talk to their parents about illegal drugs.
- Half of all parents surveyed said that the campaign had prompted them into action.

This evaluation report can be found at www.drugs.health.gov.au, in the 'campaign information' section. A link to download the evaluation report was also provided to Senator Faulkner on 4 April 2002 in response to Estimates Questions on Notice (E01000050).

(c) Phase One of the National Illicit Drugs Campaign was the critical first step in engaging, educating, and empowering Australian parents to communicate with their children about illegal drugs in order to deter the initiation or continuation of drug use amongst their children.

A second phase of specific campaign strategies addressing particular illicit drug use will follow later this year. Developmental research to underpin strategy development for this phase of the campaign has been completed and a marketing strategy is currently being finalised.

Evaluation studies are undertaken prior to the commencement of activity and at regular intervals during campaign implementation, to assess impact and to guide future strategies. At present it is simply too early to quantify the level of impact these strategies will potentially achieve.

Furthermore, while public health social marketing campaigns in Australia have shown impressive results, these campaigns work most effectively when they are part of an integrated multi-component strategy. The NIDC is part of the Commonwealth Government's Tough on Drugs plan, an integrated strategy that includes initiatives relating to education, prevention, treatment and law enforcement. Given the multiple initiatives that contribute to this strategy it would be extremely difficult to attribute a reduction in overall illegal drug use to any one component, but rather, this success would be the synergistic effect of all components combined.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-061

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS CAMPAIGN – TOUGH ON DRUGS CURRENT SERIES OF ADVERTISEMENTS

Written Question on Notice

Senator Denman asked:

The PM has recently been on TV advertising the benefits of his 'Tough On Drugs' campaign.

(a) Who paid for that program?
(b) What will be the cost of that program?
(c) What is the purpose of that program?
(d) Will that program reduce drug use in the population?
(e) Will that program be evaluated?

Answer:

(a-e) In May 2002 the Prime Minister appeared on Prime Television's 'Landscape' program and spoke about the Commonwealth Government's 'Tough On Drugs' strategy. Prime Television Services Ltd advise that they produce this program and details of the production budget are not available. The Commonwealth Government does not contribute any funds for this program. Prime Television Services advise they invite the Prime Minister of the day to appear on the program to talk about issues of interest to people in regional areas of Australia.

Evaluation of the National Illicit Drugs Campaign will not assess the impact of the 'Landscape' program as it is not part of campaign activity.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001- 2002, 5 & 6 June 2002

Question: E02-062

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: REDUCTION OF DRUG USE

Written Question on Notice

Senator Denman asked:

The latest household survey shows that during the Howard Government period of office drug use escalated and drug overdose escalated and now both use and overdoses has reduced to a figure that existed just prior to the Howard Government taking office.

(a) What plans are there to reduce that even further?
(b) What is the evidence base for those plans?

Answer:

(a) The Government has committed funding for a range of initiatives including further support for the Non-Government Organisation Treatment Grants Program and expansion of the Community Partnerships Initiative which supports communities in their effort to prevent illicit drug use.

The National Action Plan on Illicit Drugs and the National Heroin Overdose Strategy provide nationally agreed directions for addressing illicit drug issues. The Action Plan specifies key strategy areas for preventing the update of illicit drug use, and reducing the harms associated with use. The National Heroin Overdose Strategy provides nationally agreed priorities for reducing the incidence of heroin related overdose in Australia and for reducing morbidity and mortality where overdose does occur.

(b) The National Drug Strategic Framework 1998-1999 to 2002-03 sets out broad principles, policies and priority areas for reducing the harm caused by drugs in the Australian community. The National Action Plan on Illicit Drugs and the National Heroin Overdose Strategy were developed with expert input.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-063

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CRIME AUTHORITY REPORT

Written Question on Notice

Senator Denman asked:

The National Crime Authority has been very courageous in speaking out about the seriousness of the drug and organised crime problem in its 2000 commentary. Does the Government agree with the NCA's assessment on those issues.

Answer:

The Attorney General's Department has provided the following information.

The National Crime Authority launched the *Commentary on Organised Crime 2001* on 8 August 2001. The NCA is an independent statutory authority, and the Commentary addresses a wide range of issues associated with organised crime. Given the wide range of issues, the Government position is that it does not agree with each and every recommendation contained in this report.

The Government considers the views of the National Crime Authority, along with the views of other agencies with relevant expertise, and the views of those outside government, when developing its policies. In a media release on the day of the Commentary's launch, the Minister for Justice and Customs, Senator the Hon Chris Ellison welcomed "the Commentary as a valuable resource for Government in its decision and policy-making for the future."

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-064

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN NATIONAL COUNCIL ON DRUGS

Written Question on Notice

Senator Denman asked:

(a) What are the measures by which the Australian National Council on Drugs (ANCD) would be said to be a success?
(b) Has the ANCD been evaluated against those criteria?

Answer:

The ANCD has provided the following information:

Whilst there are no set measures for success in regard to the ANCD, there is a set of terms of reference that the ANCD must operate within. In addition, the ANCD has an agreed work plan of issues and actions that it addresses each 3 years. Accordingly, the ANCD does report annually to the Prime Minister and the Ministerial Council on Drug Strategy on its progress. Annual reports and the current work plan are available from the ANCD website www.ancd.org.au

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-065

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN NATIONAL COUNCIL ON DRUGS

Written Question on Notice

Senator Denman asked:

(a) When and on what occasions has the ANCD given advice to the PM or other Ministers?
(b) On how many occasions has that advice been adopted?

Answer:

The ANCD has provided the following information:

(a) The ANCD provides regular written and verbal advice to the Prime Minister and a range of Federal, State and Territory ministers, as well as many other government and opposition members of parliament. This advice is provided formally (via published reports and media releases) and informally (via meetings and discussions). It is also either specifically requested or provided as an initiative of the ANCD.

(b) The ANCD is aware that actions consistent with the advice provided by the ANCD has occurred on a number of occasions, however it is not in a position to advise on whether these actions were based solely or partly upon the advice of the ANCD.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-069

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN NATIONAL COUNCIL ON DRUGS

Written Question on Notice

Senator Denman asked:

(a) The ANCD plans to publish a periodical which includes outcomes of research. What guarantees are there that the material published is unbiased and does not follow a particular ideology?
(b) Will the research include research from overseas or be narrowly limited simply to Australian research?
(c) Will it for example include the outcomes from the Swiss, Dutch and German heroin prescription trials?
(d) Will it for example include outcomes from trials of medically supervised injecting rooms?
(e) Why is the ANCD being funded for this program and not a recognised research body such as National Drug and Alcohol Research Centre?
(f) What value will the ANCD be expected to add?
(g) Will there be a panel of recognised experts to assess the articles to be published? If so who will they be? If not why not and who will make the decisions of what to publish?

Answer:

(a-d) Contract negotiations between the Department of Health and Ageing and the Australian National Council on Drugs (ANCD) are currently under way.

(e-f) The magazine will form part of the ANCD's focus on building the capacity of the drug and alcohol workforce. Membership of the ANCD brings together a wide range of experience and expertise on various aspects of drug policy, such as treatment, rehabilitation, education, family counselling, law enforcement, research and work at the coalface in community organisations. The magazine will provide a nationally focused vehicle for reporting on drug and alcohol research and its objective will be to bridge the gap between research and practice in the drug and alcohol field.

(g) The ANCD has advised that an Editorial Board will be appointed and it is envisaged that it will consist of representatives from the ANCD, non-government organisations, the National Research institutions, the Commonwealth Government, service providers and possibly the Intergovernmental Committee on Drugs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-066

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: ECONOMIC COST OF DRUGS - STUDIES

Written Question on Notice

Senator Denman asked:

(a) What studies have been undertaken, or are planned to be undertaken, to identify the total cost of drugs to Australian Society?
(b) Can those costs be identified in terms of annual turnover? For example how much is spent on illegal drugs, how much is spent on treatment, how much is spent on interdiction, how much is spent on the judicial system?
(c) Overseas studies indicate that treatment can be up to seven times more effective than interdiction. What is the Australian experience in this respect?
(d) Could it be said on that basis that expenditure in Australia is therefore the most effective distribution of funds?

Answer:

(a) In 1996, the publication *'The social costs of drug abuse in Australia in 1988 and 1992'* developed by Professor David Collins and Ms Helen Lapsley, was produced as a National Drug Strategy (NDS) Monograph (No. 30).

The second in a series produced as NDS Monographs, the publication presented individual cost estimates for alcohol, tobacco and illicit drugs. In addition to the abuse cost estimates, the study provided information on which sectors of the community (private individuals, business or government) bore the initial impact of those costs. It also estimated the proportion of costs that were potentially avoidable and the budgetary impact of drug abuse (in terms of the effects on revenues and expenditures of Commonwealth and State governments).

Professor Collins and Ms Lapsley have been contracted by the Department of Health and Ageing to revise and update *'The social costs of drug abuse in 1988 and 1992'* for the most recent year for which analysis is possible (target 1998). The methodology and procedures employed by the consultant in their 1996 study will also be addressed during the course of this update.

(b) Due to the complex nature of the methodology used to estimate these costs and the stability of the estimates over short periods of time, the production of annual estimates would not be a cost-effective option for government.

In addition to the estimates produced in 1996 on issues such as the unpaid workforce, road accidents, loss of life, pain and suffering and avoidable costs; estimates will be produced on general health costs, crime, ambulances and fires for tobacco, alcohol and illicit drug use in the revised Collins and Lapsley study described above.

(c) The Department is not aware of any Australian studies at this time.

(d) The Department is not aware of any Australian studies at this time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-067

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: DRUG TREATMENT PLACES

Written Question on Notice

Senator Denman asked:

(a) How many and what type of treatment places for drug abuse exist in Australia?
(b) What funds have been put into drug treatment on an ongoing or once only basis?
(c) How many of those are funded by the Federal Government?
(d) Over the last 10 years on a year by year basis what has been the number of persons on a methadone program?

Answer:

(a) The 2001 Clients of Treatment Service Agencies (COTSA) census shows that the total number of clients in treatment at any one time in 2001 ranged from 51, 000 to 68,000.

Due to the nature of the collection (a one day census) clients being treated in residential services are likely to have been counted, whereas a large number of clients in non-residential treatment who were not seen on census day were not counted. The actual number of clients being treated for drug and alcohol problems is higher than the census findings indicate.

Services provided include assessment and referral, outpatient counselling, methadone and counselling, outpatient detoxification, rapid detoxification, inpatient detoxification, inpatient rehab or therapeutic community, methadone maintenance and other pharmacotherapies.

(b) Under the Tough on Drugs National Illicit Drug Strategy Non Government Organisation Treatment Grants Program the Commonwealth Government has allocated funding of $57 million to 133 drug treatment services over four years. In December 2001 the Government announced a further allocation of $61.6 million to continue the Non Government Organisation Treatment Grants Program. This funding was confirmed in the May 2002 Federal Budget.

(c) See answer to (b).

(d)

At 30 June	No of Clients	At 30 June	No of Clients
1991	**9694**	*1997*	**22239**
1992	**11244**	*1998*	**24657**
1993	**12989**	*1999*	**27906**
1994	**14996**	*2000*	**30237**
1995	**17356**	*2001*	***32516**
1996	**19573**		

* Includes clients in both methadone and buprenorphine programs.

Source: Commonwealth Department of Health and Ageing with input from States and Territories.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-068

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: RESEARCH INTO TREATMENT FOR DRUG ADDICTION

Written Question on Notice

Senator Denman asked:

What research is being undertaken into treatment for addiction to drugs such as methamphetamine and cocaine or other newly emerging drugs?

Answer:

The Commonwealth is currently funding several initiatives to inform the management of emerging health and social issues associated with the misuse of psychostimulants including:

An evaluation of cognitive-behavioural therapy in the treatment of regular amphetamine users

The project will document the outcomes of a controlled trial of relapse prevention and brief intervention among regular users of amphetamines, and (if successful) develop an appropriate dissemination strategy for the interventions to service providers, including intervention manuals and client handouts.

Updating the National Drug Strategy Monograph no. 32 'Models of Intervention and Care for Psychostimulants Users'

The update of the Monograph includes a review of the research evidence in respect to treatment interventions for a range of psychostimulants including amphetamines, MDMA and cocaine. In addition, the project will develop and trial clinical practice guidelines on the management of acute psychostimulant toxicity (including cocaine toxicity) for ambulance officers, accident and emergency workers and police.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-070

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: HEROIN TRIAL

Written Question on Notice

Senator Denman asked:

(a) The PM has frequently stated that he opposes the trial of heroin on prescription for severely addicted persons. He opposes because he claims it will send the wrong message. Just what is that message that must not be sent?
(b) What is the evidence that it will in fact send the wrong message?
(c) How does that message compare with the deaths of over 3,000 people from overdose, some of whose lives might have been saved by prescription heroin?

Answer:

(a) As indicated by the Prime Minister on a number of occasions, the Commonwealth Government does not support a heroin trial in Australia. The Federal Government believes that funding is better spent on community based treatment programs that aim to get people off drugs.
(b) According to an independent evaluation conducted by the World Health Organisation of the Swiss Heroin Trial in 1999, the trial did not produce any evidence to suggest that prescribed heroin would produce improved outcomes compared to therapies such as methadone and buprenophine. In its 2001 Annual Report, the International Narcotics Control Board criticised injecting rooms by stating: *'The operation of such facilities, where addicts inject themselves with illicit substances, condones illicit drug trafficking and runs counter to the provisions of the international drug control treaties.'*
(c) See (b).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-071

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: HARM MINIMISATION

Written Question on Notice

Senator Denman asked:

Harm minimisation is the overarching policy for drug issues.

(d) Are there attempts to reduce or remove harm minimisation as that overarching policy?
(e) What is the relationship between harm minimisation and the Tough on Drugs Strategy?

Answer:

(a) There has been no change to the Government's approach to drug policy. The Government is aiming to reduce illicit drug use and the harm it causes.

(b) The Government's Tough on Drugs Strategy is the 'overarching' approach to tackling Australia's illicit drug problem. The Strategy is an integrated and balanced plan that aims to reduce the demand for and supply of illicit drugs. A basic tenet of the strategy is that illicit drug use is highly dangerous, that there is no safe level of use and that abstinence should be the main objective of treatment. The strategy also builds the 'social coalition' through a partnership between the Government and the community, reflected in the advisory role of the Australian National Council on Drugs (ANCD). Key initiatives pursued through the ANCD are the NGO Treatment Grants Programme and the Community Partnership Initiative. The NGO Treatment Grants Programme provides funds to community treatment services to help drug users move toward a drug free lifestyle. The Community Partnership Initiative helps communities build coalitions of community groups seeking to prevent illicit drug use at the local level. Overall, the Commonwealth Government has provided $625 million for Tough on Drugs. There is now clear evidence that the Strategy is working, with recent figures showing marked declines in drug overdose deaths and illicit drug use and marked increases in illicit drug seizures.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-100

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: REVIEW OF TOBACCO ADVERTISING

Written Question on Notice

Senator Evans asked:

Last week the Minister announced a review of tobacco advertising guidelines to take into account new advertising techniques that are used to persuade young people to take up smoking.

(a) Who will conduct this review?
(b) What are the guidelines?
(c) What is the timeline for this review to report back?

Answer:

(a) The review will be conducted by the Department of Health and Ageing. An advisory panel comprising legal, public policy, public health, broadcasting and tobacco control expertise will advise the Department throughout the course of the review.

(b) The review will consider whether the Act has met its objective of limiting the exposure of the public to messages and images that may persuade them to start or continue smoking. It will also consider whether the objectives of the Act should be expanded to take into account new and emerging advertising and sponsorship practices. Five key areas will be examined:

- legislative definitions and provisions contained in the Act and whether they remain current and workable;
- emerging technology and media as well as contemporary advertising, marketing and sponsorship practices;
- extent and impact of media reporting and portrayal of smoking in the media;
- administration and enforcement of the Act; and
- current exceptions to the Act and their continued relevance.

(c) The review will report by the end of the year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-101

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FRAMEWORK CONVENTION ON TOBACCO CONTROL

Written Question on Notice

Senator Evans asked:

Budget Portfolio Statements describe Australia as having a leadership role in the facilitation of Western Pacific Regions participation in the development of the Framework Convention on Tobacco Control (FCTC) in building the tobacco control capacity in the region (this work is done in conjunction with AusAID).

(a) Outline the resources ($ and people) provided for this effort and progress against objectives?
(b) What data is available to show that Australia's efforts in this regard are having an effect?

Answer:

(a)

Financial Year	**Aus $**
1999-00	150,000
2000-01	30,770
2001-02	276,000

Approximately 25% of two full-time equivalents manage the Department's support to the Western Pacific Region in relation to building capacity in tobacco control and facilitating participation in the FCTC.

The objectives of Australia's support to the Region are:

- to assist member states in the Region to have meaningful participation in the FCTC; and
- assist with and facilitate member states' access to technical advice on tobacco control.

A key component of Australia's support to the Region is funding of a tobacco control Adviser based at the Western Pacific Regional Office (WPRO).

In regard to assisting member states to have meaningful participation in the FCTC:

- an increasing number of countries in the Region are engaging in FCTC related activities and sending delegates/delegations to the FCTC Intergovernmental Negotiating Body (INB) meetings in Geneva (see data at (b) below); and
- the delegate from Palau now chairs meetings of the Western Pacific Regional group and is supported by Australia as the Bureau representative of the Region.

In regard to assisting with and facilitating access to technical advice, an increasing number of countries in the Region are seeking technical advice from the Australian funded Adviser based in WPRO.

(b) 19 of 28 WHO member states in the Region attending the second Intergovernmental Negotiating Body meeting in May 2001 and 23 attending the third negotiating meeting in November 2001.

No quantitative data is available to show the effect of Australia's support to the Region in terms of building capacity in tobacco control, however, a WPRO publication *Country Profiles on Tobacco or Health 2000* provides baseline data on smoking prevalence and tobacco control measures in WPRO member states.

Monitoring of progress is done at a regional level, predominantly by WPRO. The Department of Health and Ageing understand that WPRO intend updating the publication *Country Profiles on Tobacco or Health 2000*, which will facilitate comparison of tobacco control measures prior to and post 2000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-102

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: ANTI-SMOKING PROGRAMS

Written Question on Notice

Senator Evans asked:

The Federal Government currently provides $2.3 million for anti-smoking programs. Yet each year 19,000 Australians die of tobacco related diseases. In the recent Intergovernmental Report, the Government outlined its concern about the future healthcare and disability costs. It is now taking steps to limit these in the future.

(a) Will this include spending more on anti-smoking programs?
(b) If not, why not?

Answer:

(a) The Government's appreciation of the health and social impacts of tobacco, and its commitment to addressing tobacco-related harms, is well-established.

The 2002-03 Budget provides continued funding to a range of nationally significant preventive public health programs, including tobacco harm minimisation. Total funding for these preventive health measures (which also include measures relating to the agreed National Health Priority Areas, their common risk factors and at-risk groups) is $22.8 million in 2002-03, $23.3 million in 2003-04, $23.8 million in 2004-05 and $24.3 million in 2005-06.

This funding will enable a continued investment in the National Tobacco Campaign and National Tobacco Strategy, especially in the area of young people, and will see the Commonwealth continue to add to the efforts of States and Territories in tobacco control and consolidate our world leadership in this important public health area.

(b) As above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-103

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: INCREASE IN TGA FEES FOR REVIEW OF PHARMACEUTICALS OVER THE PAST 5 YEARS

Written Question on Notice

Senator Evans asked:

(a) How have fees for the review of pharmaceuticals submitted for registration on the Australian Therapeutic Goods list risen over the past 5 years?
(b) What are the factors that have caused the increases over this time? Please provide details.

Answer:

(a-b) To coincide with the implementation of the *Therapeutic Goods Act 1989* (the Act) in April 1991 the then Government decided the Therapeutic Goods Administration (TGA) would recover 50% of all its operating costs through fees and charges collected from the therapeutic goods industry.

In its first full year of operation 1991/92, the TGA recovered approximately 30% of its operating costs. With agreement from Government and industry, fees and charges were increased gradually until the 50% target was reached by 1 July 1996.

As part of the 1996/97 Budget strategy, the Government decided to increase the level of cost recovery to 58% in 1996/97, to 67% in 1997/98 and to 75% in 1998/99.

In framing the 1997/98 Budget, the Government decided to accelerate the rate of increase in the level of cost recovery, moving to 75% in 1997/98 and to full cost recovery in 1998/99. All activities that fall within the scope of the Act are cost recovered including pre market evaluation of applications and post market monitoring.

In 1996, the Government decided to reform the management of Commonwealth property, including the Special Purpose and Industrial Estate of which the TGA Symonston complex is a part. As a consequence, from 1 July 2001 the rent paid by the TGA increased by $3.317 million per annum. This increase has been phased in over three years – by $1.5 million in each of 2001/02 and 2002/03 with the balance to be introduced in 2003/04. Fees and charges have therefore been adjusted to reflect this increase.

During 2000/01, the TGA and industry agreed that future fee increases should be reflective of indices produced externally to the TGA. It was agreed that a 50/50 composite of the Consumer Price Index (CPI) and the Wage Cost Index (WCI) for the year ended December would be appropriate for future years. This reflects the 50/50 break-up of TGA costs between external supplier and staff costs.

Fees and charges increased in 2001/02 by 6.6% made up as follows:

50% annual WCI for year ended December	1.55%
50% annual CPI for year ended December	1.75%
Increased rent ($1.5 million)	3.3%

Fees and Charges will increase in 2002/03 by 6.3% made up as follows:

50% annual WCI for year ended December	1.75%
50% annual CPI for year ended December	1.55%
Increased rent ($1.5 Million, second tranche)	3.015%

The cost of evaluating a new prescription medicine or a change to an existing prescription medicine depends on the volume and type of data – usually chemistry, toxicology and clinical data, to be evaluated. As indicated above, fees in 2001/02 and 2002/03 have also been affected by the increase in rent to be paid by the TGA for its special purpose building at Symonston.

The following table illustrates the cost of evaluating a data package of 10,000 pages submitted to the TGA in support of an application to supply a new chemical entity (prescription medicine) each year since 1 July 1996 when the TGA was required to recover 50% of all its operating costs. This is a typical example of how fees and charges have moved over the period.

	Actual Cost $	Level of cost recovery applied	Equivalent 100% Cost $	Indexed to 2000/01 prices
95/96	130,200	50%	260,400	290,701
96/97	137,500	58%	237,069	262,900
97/98	153,300	75%	204,400	225,316
98/99	162,000	100%	162,000	174,239
99/00	168,000	100%	168,000	175,924
00/01	168,000	100%	168,000	168,000
*01/02	179,090	100%	179,090	179,090

*includes relevant proportion of $1.5 million for increased rent; CPI/WCI for 2001/02 not yet available

In this example:

1. The data package includes
    - 3000 pages chemistry data
    - 2000 pages toxicology data
    - 5000 pages clinical data
2. The index used is half the annual CPI plus half the annual WCI for each financial year over the 5-year period to and including 2000/01 as applied to fees and charges in 2001/02 and proposed for 2002/03.

Comment*:*
The Table illustrates that the real cost of TGA fees and charges for prescription medicines has fallen by 38% since 1995/96. This reflects the efficiency gains achieved by the TGA and passed on to industry through cost reductions over this period.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001-2002, 5 & 6 June 2002

Question: E02-104

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL CERVICAL SCREENING PROGRAM

Hansard Page: CA153

Senator Evans asked:

Given the high rates of cervical cancer amongst Aboriginal and Torres Strait Islander women, what initiatives are underway to ensure that these women have access to culturally sensitive cervical screening services on a regular basis?

Answer:

The National Cervical Screening Program (NCSP) has taken a number of steps to address the high rates of cervical cancer amongst Aboriginal and Torres Strait Islander women.

- In February 2000 an Aboriginal and Torres Strait Islander Women's Forum was established by the NCSP. This group has met several times and has developed a workplan, with specific goals to address increasing the participation in the screening program by Aboriginal and Torres Strait Islander women. The Forum is a Working Group to the National Advisory Committee to the National Cervical Screening Program, and three of its members also sit on the National Advisory Committee. Membership of the Forum is broad, including members from the government, community controlled and consumer sectors. All members are Indigenous.

- The Public Health Outcome Funding Arrangements between the Commonwealth and each State and Territory include an indicator specifically requiring that steps be taken to improve cervical screening among Aboriginal and Torres Strait Islander women. This includes the establishment of collaborations and partnerships with Indigenous communities, so as to make progress towards meeting targets agreed by the Australian Health Ministers Advisory Council.

- State and Territory programs also receive funding to undertake specific activities designed to promote participation and access by Aboriginal and Torres Strait Islander women.

- Further, the Commonwealth has provided a grant to Queensland Health to produce guidelines for culturally appropriate screening services provided to Aboriginal and Torres Strait Islander women. The aim of this project is to develop a resource package to assist cervical cancer prevention and control organisations to ensure that their services are appropriate and accessible to Aboriginal and Torres Strait Islander women.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-007

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FAMILY PLANNING AGENCIES

Written Question on Notice

Senator Brian Harradine asked:

Please provide allocations approved for family planning agencies for 2001-2002 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 2001-2002:

Organisation	**2001-2002**
	($)
FP NSW	4,741,214
FP VIC	1,947,764
FP QLD	2,727,530
FP WA	1,557,412
FP TAS	509,506
FP NT	411,204
SHFPA	91,186
WWH	103,661
AC BISHOPS	836,469
AFPSS	230,060
Total	**13,156,008**

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-098

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: EGYPTIAN REACTOR BUILT BY INVAP

Written Question on Notice

Senator Forshaw asked:

In October 2001 Dr John Loy and Mr Don Macnab visited Egypt to examine the nuclear reactor built by INVAP.

(a) What was the purpose of the visit?
(b) What was the outcome of the visit?
(c) In particular what technical difficulties have been experienced with the operation of the Egyptian reactor?
(d) Do any of these difficulties or problems have implications for, or give rise to, concerns over safety?
(e) Is the reactor operating at full power? If not why not?
(f) If not then when is it expected to be operating at full power?
(g) Does INVAP still have any involvement with the operation, maintenance of the Egyptian reactor?
(h) Is INVAP involved in fixing any of the current problems or difficulties with the Egyptian reactor?
(i) Has INVAP been paid in full for the construction of the Egyptian reactor?
(j) Is the operator satisfied with the Egyptian reactor?

Answer:

(a-d) The purpose of the visit (in September 2001) was to hold discussions with the Egyptian Atomic Energy Authority and to inspect the ETRR 2 reactor. This was in the context of the assessment of ANSTO's application to construct the replacement research reactor.

During the discussions, it became clear that there were a small number of technical issues that needed resolution if Egypt were to operate the reactor at full power. In particular, the method of calculating the power peaking factor in the reactor core and the formation of bubbles in the reactor pool were significant issues.

With regard to the Australian replacement research reactor, substantial additional analyses have been undertaken of the power peaking factor and ARPANSA was satisfied in the context of the construction licence decision. Due to the different reflector system in the Australian reactor, the bubbles are probably not relevant.

(e-f) The reactor was not operating at full power in September 2001 as the Egyptian regulatory authority had not licensed it for routine operation at its maximum designed power, pending the technical issues being resolved. ARPANSA has no specific information on when it is expected to operate at full power.

(g-j) In September 2001, INVAP had no specific involvement in the operation and maintenance of the Egyptian reactor but was involved in resolving the technical and contractual issues. ARPANSA has no specific information on INVAP's current involvement. Additionally, ARPANSA has no specific information on payments to INVAP for the construction of the Egyptian reactor or about the current operator satisfaction with the reactor.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-099

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: THREAT OF TERRORISM OR SABOTAGE

Written Question on Notice

Senator Forshaw asked:

(a) Has ARPANSA prepared a report on the potential consequences of a successful sabotage attack on the existing or proposed new reactor?
(b) If so, will ARPANSA provide the Committee with a copy of the report?
(c) If so, will the Report be made public?
(d) If not, why not?

Answer:

ARPANSA Regulatory Branch performed radiological consequence analyses for a range of accidents for the ANSTO Replacement Research Reactor, including for sabotage, in order to independently check the analyses undertaken by ANSTO. The results of these analyses have been referred to in the reasons for decision on the construction licence issued by the CEO and are summarised in the Regulatory Branch assessment report of the licence application (RB-ASR-09-02) which is posted on ARPANSA's web site. The CEO of ARPANSA is considering what further information could be usefully made available to the public, without compromising the security related to the information.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-076

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL ILLICIT DRUGS STRATEGY

Hansard CA154

Senator Denman asked:

What are the categories, or sub-programs, and amounts in these categories (in addition to what has been spent under the National Illicit Drugs Strategy) for each of those years to date from 1996?

Answer:

It is not possible to provide detailed information on the specific funding provided for activities under the National Drug Strategy. The funding for the National Population Health Program, which includes the National Drug Strategy, has been broadbanded into a one-line appropriation. This also includes the funding to the States and Territories under the Public Health Outcome Funding Agreements (PHOFAs). In line with the broad directions of COAG, the PHOFAs ensure that national public health priority outcomes are achieved, whilst allowing States and Territories flexibility in determining how resources will be deployed in order to achieve the outcomes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-077

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN NATIONAL COUNCIL ON DRUGS - FUNDING

Written Question on Notice

Senator Denman asked:

(a) Have you any idea how much has been paid each year to the Chairman and Deputy Chairman?
(b) What are their travelling costs?

Answer:

The ANCD has provided the following information:

(a) In the 9 months to 31 March of the current financial year (2001-02) the Chairman has received $54,513. This amount includes all airfares, other travel costs, accommodation costs, travelling allowances, sitting fees, staff support and office expenses. The Deputy Chairman has received $765. This figure is substantially lower due to the Deputy Chairman being a senior Commonwealth public servant and not requiring office or travel assistance or being eligible to receive sitting fees.

(b) Whilst all members are entitled to be paid in accordance with the latest Remuneration Tribunal Report and Decisions on sitting fees and travel allowances, which can vary according to the location of meetings, it should be noted that the ANCD Deputy Chair and Australian Federal Police (AFP) Commissioner, has chosen to follow the travel policy that applies across the AFP, that is, reimbursement of travel costs incurred.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-078

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: TERMS OF REFERENCE OF NON GOVERNMENT ORGANISATIONS TREATMENT GRANTS PROGRAM

Written Question on Notice

Senator McLucas asked:

Would the Committee be able to have a copy of those terms of reference when they have been developed?

Answer:

Yes, a copy of the terms of reference will be provided to the committee when they are available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-079

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: DRUGS

Hansard Page: CA157

Senator Crowley asked:

So somewhere in the Department it should be easy enough to find the last estimate of what are the alternative drugs, both made at home and coming in?

Answer:

The following information has been provided by the Australian Federal Police.

All heroin (apart from some minor amounts of 'home-bake'), and all cocaine consumed in Australia is illicitly imported into Australia, as is most MDMA (ecstasy) and an increasing amount of methamphetamine. While there is some local production of methamphetamine, and rarely MDMA, given the illicit nature of their production the degree of production cannot be accurately estimated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02- 080

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NEEDLE STICK INJURIES

Hansard Page: CA158

Senator West asked:

How many people in health care settings have contracted diseases as a result of needle stick injuries?

Answer:

In Australia, the majority of needle stick injuries occur in health care settings through occupational exposure. This mirrors the international experience.

The gathering of data on occupationally acquired blood borne viruses from needle stick injuries is not systematically collected in Australia, with the exception of HIV. Data indicates that that there have been approximately six cases of HIV acquired from needle stick injuries in occupational settings since data collection commenced in the early 1990's. However, prospective studies of health care workers occupationally exposed to blood-borne viruses have estimated that the average risk of transmission after an exposure to infected blood is:

- HIV - 0.3% (3 per 1000)
- Hepatitis B – 6%-30% (6-30 per 100)
- Hepatitis C – 3%-10% (3-10 per 100)

Comprehensive national data will be collected and assessed as part of the initial public health research phase of the 2002-2003 Retractable Needle and Syringe Budget initiative.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-081

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: RETRACTABLE NEEDLES

Hansard Page: CA160

Senator West asked:

(a) What international research do we know of on the use of retractable needles?
(b) Do we know what sort of technology is used overseas?
(c) What is the usage rate over there?

Answer:

(a) At this stage, the Department is aware of some international research around the use of retractable technology:

- In the United States, the *Needlestick Safety and Prevention Act* was passed in November 2000 and revised in 2001. The Act provides for the requirement that employers select safer needle devices (such as retractable needles and syringes) as they become available and involve employees in identifying and choosing those devices.

- On 24 October 2001, the *Ottawa Citizen* reported that Ottawa's health department is considering a pilot project to trial retractable needles and syringes for use in its Needle and Syringe Programs. The article noted that such a trial may be the first of its kind in the world and that retractable technology has not been used outside the health care setting. Implementation of a feasibility study was scheduled to begin in April 2002.

The 2002-2003 Budget initiative on retractable needle and syringe technology will include a literature search and analysis to review the status and impact of the introduction of retractable needle and syringe technology throughout the world.

(b) The Department is aware that there is a range of safety and retractable needle and syringe technologies available for use in Australia and overseas. A number of these have been brought to the attention of the Department by medical device manufacturers and distributors since the retractable Needle and Syringe initiative was announced as part of the 2001 Federal Election.

(c) The Department is currently unaware of the usage rate in Australia or overseas of retractable technology. However these issues will be considered as part of the initial public health research phase.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-250

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FUNDING FOR ANTI-TOBACCO PROGRAMS

Hansard Page: CA164

Senator McLucas asked:

Can you explain to me, please, how much we are talking about for anti-smoking programs in 2002-03 and then the out years?

Answer:

The 2002-03 Budget provides continued funding to a range of nationally significant preventive public health programs, including tobacco harm minimisation. Total funding for these preventive health measures (which also include measures relating to the agreed National Health Priority Areas, their common risk factors and at-risk groups) is $22.8 million in 2002-03, $23.3 million in 2003-04, $23.8 million in 2004-05 and $24.3 million in 2005-06.

This funding will enable a continued investment in the National Tobacco Campaign and National Tobacco Strategy, especially in the area of young people, and will see the Commonwealth continue to add to the efforts of States and Territories in tobacco control and consolidate our world leadership in this important public health area. The quantum of that investment in each year will reflect the priorities of the Government and the strategic opportunities available for investment.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-082

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FAMILY PLANNING CLINICS

Hansard Page: CA164-5

Senator Rosemary Crowley asked:

(a) How many people attended family planning clinics last year?

(b) Could you also give us any subsections of what the people are visiting family planning for? I understand that people visit for education, for direct advice, for service provision, for counselling.

Answer:

Client visits and services provided by Family Planning Organisations[(a)] for the 2000–2001 financial year are as follows:

Type of service provided	**2000–2001**
Contraceptive services	70,584
Reproductive and sexual health management[(b)]	44,061
Early intervention/health promotion services[(c)]	68,541
Total services	183,186
Number of client visits	126,720

(a) Excludes South Australia.

(b) Includes management of menstrual irregularity, sexually transmitted infections and menopause, antenatal checks, postnatal checks and post-termination checks.

(c) Includes Pap smears, breast checks, pregnancy tests, investigation and care of sexually transmitted infections, rubella tests and hepatitis tests.

Source: Sexual Health and Family Planning Australia national database.

NB. There are definitional differences between Family Planning Organisations in the recording of clinical service use data. The Commonwealth and the Family Planning Organisations are currently developing a nationally consistent data proforma to address the discrepancies in this type of reporting.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-083

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FAMILY PLANNING AGENCIES

Hansard Page: CA 165

Senator Harradine asked:

Where a person presents as being pregnant (to a Family Planning Clinic) what percentage of those end up having an abortion.

Answer:

The Department does not have figures on the percentage of those pregnant women who present at family planning clinics who end up having abortions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-084

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: FAMILY PLANNING AGENCIES

Hansard Page: CA 168

Senator Harradine asked:

What percentage of that group which was mentioned have been referred to registered pregnancy support for counselling services?

Answer:

The Department undertook to contact the family planning organisations to seek this information. The responses are:

Family Planning Queensland	information not available
Family Planning Victoria	information not available
Family Planning Welfare Association of NT	information not available
FPA Health (NSW)	information not available
Family Planning Association of WA Inc	All clients presenting with unplanned pregnancy and considering an abortion are always referred for pregnancy counselling as required by Western Australia State legislation.
Family Planning Tasmania	information not available

Specific statistics are not available because family planning organisations do not keep statistical records of that nature.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001-2002, 5 & 6 June 2002

Question: E02-085

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NATIONAL YOUTH ALCOHOL CAMPAIGN

Hansard Page: CA170

Senator Buckland asked:

(a) I would like to see what you have got (evaluation reports on the campaign)?
(b) Can you provide hard copies of the research on the campaign ?

Answer:

(a) The following evaluation reports on the National Alcohol Campaign are available and can be found at www.nationalalcoholcampaign.health.gov.au in the 'stakeholder' section under 'research and evaluation':

- Shanahan, P. and Hewitt, N. (1999). *Developmental Research for a National Alcohol Campaign: summary report*. Commonwealth of Australia, Canberra.
- Carroll, T., Lum, M., Taylor, J and Travia, J. (2000). *Research summary: Evaluation of the Launch Phase of the National Alcohol Campaign.* Commonwealth of Australia, 2000.

(b) An evaluation report of the 2001 booster phase of the campaign is currently being finalised. The Minister will make a decision on its public release.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-086

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: MENINGOCOCCAL VACCINE

Hansard Page: CA 174

Senator Denman asked:

Why is there such a shortage worldwide?

Answer:

The following information has been received from the company that supplies meningococcal C conjugate vaccine to the Australian market:

- The company have recently experienced several quality control problems. This has led to a number of 'batch failures'.

- The company is obliged to prioritise their supply to governments for their funded vaccination programs. Several European countries are in the process of including meningococcal C conjugate vaccine in their national vaccination schedules, adding to the shortage for the private market worldwide.

The production cycle for this particular vaccine is nine months. Therefore, supplies of meningococcal C conjugate vaccine from this company are not expected to return to normal until early 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-087

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: DEEP VEIN THROMBOSIS

Hansard Page: CA179

Senator West asked:

Are courts already awarding compensation for this condition (deep vein thrombosis)?

The Secretary of the Department (Ms Jane Halton) indicated that this may not be a question that the Department can answer.

Subsequently, Senator West raised the possibility that if the courts accept evidence linking DVT to air travel, and the scientific evidence proved to be negative, this would "raise some interesting...".(CA 179)

Answer:

The importance of epidemiological evidence, of the kind sought in the record linkage study sponsored by government, is that it will go beyond the anecdotal information currently available, to quantify the strength of any affect of air travel on the risk of DVT.

In particular, if a positive result is found, it will allow an inference to be drawn about the average probability (technically called the attributable risk), that a particular DVT event, occurring after air travel by a particular person, has actually been caused by the travel. Courts would then be able to use such information and decide on the level of probability that it might accept in establishing a causal link for a particular person. Of course, there would be other factors (eg prior information given by an airline to prospective travellers) that would need to be assessed in relation to any determinations for liability purposes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-035

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: POSTINOR-2 EMERGENCY CONTRACEPTIVE

Hansard Page: CA 184

Senator Harradine asked:

Question:

The TGA undertook to provide information about the effectiveness (of Postinor-2) seen in clinical trials, as published in the prescribing information.

Answer:

A copy of the Australian approved product information for Postinor-2 is attached.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-036

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: AUSTRALIAN GOVERNMENT SOLICITOR - REQUEST FOR LEGAL OPINION CONCERNING MORNING-AFTER PILLS

Hansard Page: CA 187

Senator Harradine asked:

Would you provide to the committee the instructions that you gave in your request to the Australian Government Solicitor so we know what you said to the Australian Government Solicitor?

Answer:

Attached is a copy of the request to the Australian Government Solicitor for advice concerning morning-after pills.
[Note: the attachment has not been included in the electronic/printed volume]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-092

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: NORTHERN TERRITORY PETROL SNIFFING DIVERSION PROJECT

Hansard Page: CA 227

Senator McLucas asked:

(a) Can you provide a description of the petrol sniffing diversion pilot project?
(b) Can you provide the committee with the number of people that will be served by the petrol sniffing diversion pilot project?

Answer:

(a) In February 2001, the Prime Minister announced that funding of $1 million would be made available to the Northern Territory for petrol sniffing diversion projects, aimed at diverting primarily young experimental petrol sniffers and those at risk of petrol sniffing into community supported early intervention and prevention initiatives.

Three projects were selected to receive funding under this initiative. They are as follows:

Darwin Skills Development Scheme

This project aims to provide an holistic and coordinated approach to addressing issues for young people by developing and fostering links between major stakeholders, including councils, elders, community members, related service providers (youth, education, health, family services) and young people.

Arrguluk CDEP

This project involves the employment of a youth worker, increasing the level of youth activities (including a horse training project, a trail riding project and development of a scouts group), developing youth work skills among the Bininj people, community education and coordination of existing resources.

Tangentyere Council representing Central Australian Indigenous Service Network

This project ("Youth Link-Up Service") will establish a community controlled specialist inhalant misuse prevention and intervention unit. The unit will facilitate the development and coordination of prevention strategies such as: after-school care programs, holiday programs and targeted youth activities including specialist support and counselling.

(b) It is difficult to estimate the number of people who currently sniff petrol across communities in the Northern Territory as these numbers fluctuate, and the practice can flare up or abate in a community quite quickly. As such, the projects are aimed at a whole of community level and at all young people, rather than just at those people who currently sniff petrol.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-249

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: EMERGENCY CONTRACEPTIVES

Hansard Page: CA 287

Senator Herron asked:

Is the question of when conception occurs relevant to the operation of the Therapeutic Goods Act?

Answer:

For the purposes of the operation of the *Therapeutic Goods Act 1989* (the Act) it is not necessary to define the term "conception". The relevant term in the Act is "abortifacient", and we have received advice from the Australian Government Solicitor that abortion cannot occur prior to implantation. We are acting in accordance with this advice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-047

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: ZYBAN ANTI-SMOKING AGENT

Hansard Page: CA 315

Senator West asked:

(a) What are the interactions that Zyban has with other medications if it is an antidepressant?
(b) What about other antidepressants or other tricyclics?

Answer:

(a) Zyban (bupropion) is not approved in Australia for use as an antidepressant. It is approved as a short- term adjunctive therapy for the treatment of nicotine dependence. The *Interactions* section of the Australian approved Product Information (PI) for Zyban includes information about the possible effects Zyban may have on other medications and vice versa, as follows:

"Interactions

It is important to be aware of all medicines which patients are taking when considering their suitability for Zyban treatment. Zyban may interact with a number of medicines by lowering the seizure threshold (see Precautions) or through other mechanisms.

In patients receiving medicinal products known to lower the seizure threshold, Zyban must only be used if there is a compelling clinical justification for which potential medical benefit of smoking cessation outweighs the potential increased risk of seizure (see Precautions).

Physiological changes resulting from smoking cessation itself, with or without treatment with Zyban, may alter the pharmacokinetics of some medications taken concomitantly.

In vitro findings indicate that bupropion is metabolised to its major active metabolite hydroxybupropion primarily by the cytochrome P450 IIB6 (CYP2B6) (see Actions, Pharmacokinetics). Care should therefore be exercised when Zyban is coadministered with drugs known to affect the CYP2B6 isoenzyme (e.g. orphenadrine, cyclophosphamide, ifosfamide).

Although bupropion is not metabolised by the CYP2D6 isoenzyme, in vitro human P450 studies have shown that bupropion and hydroxybupropion are inhibitors of the CYP2D6 pathway. In a human pharmacokinetic study, administration of bupropion hydrochloride increased plasma levels of desipramine. This effect was present for at least seven days after the last dose of bupropion hydrochloride. Concomitant use of Zyban with other drugs metabolised by the CYP2D6 isoenzyme has not been formally studied. Therefore, concomitant therapy with drugs predominantly metabolised by this isoenzyme (such as certain beta-blockers (e.g. metoprolol), antiarrhythmics (e.g. flecainide), SSRIs, TCAs, antipsychotics) should be initiated at the lower end of the dose range of the concomitant medication. If Zyban is added to the treatment regimen of a patient already receiving a medication metabolised by CYP2D6, the need to decrease the dose of the original medication should be considered, particularly for those concomitant medications with a narrow therapeutic index (see Actions, Pharmacokinetics).

Since bupropion is extensively metabolised, the coadministration of drugs known to induce metabolism (e.g. carbamazepine, phenobarbitone, phenytoin) or inhibit metabolism (e.g. valproate) may affect its clinical activity.

Limited clinical data suggest a higher incidence of neuropsychiatric adverse events in patients receiving bupropion concurrently with either levodopa or amantadine. Administration of Zyban to patients receiving either levodopa or amantadine concurrently should be undertaken with caution.

Although there is no clear evidence, it is possible that an interaction may occur between bupropion and the herbal remedy St John's Wort (Hypericum perforatum), which may result in an increase in undesirable effects."

(b) There are currently 48 brands of antidepressant approved for marketing in Australia. The Australian approved PI documents for all of these products should include information about the possible effects the antidepressant may have on other medications and possible effects other medications may have on the antidepressant.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-251

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: CIGARETTE SMOKING INCIDENCE – THE 2001 NATIONAL DRUG STRATEGY HOUSEHOLD SURVEY: FIRST RESULTS REPORT RELEASED BY THE AUSTRALIAN INSTITUTE OF HEALTH AND WELFARE ON 23 MAY 2002.

Hansard Page: CA 410

Senator Herron asked:

If you could get me a copy of the Australian Institute of Health and Welfare document (in relation to cigarette smoking incidents dropping below 20 per cent) you referred to, I would appreciate that.

Answer:

A copy of the Australian Institute of Health and Welfare report '2001 National Drug Strategy Household Survey: First Results' is attached.

The report may be accessed at:
http://www.aihw.gov.au/publications/phe/ndshs01/index.html

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-088

OUTCOME 1: POPULATION HEALTH AND SAFETY

Topic: SUBSTANCE USE - TOBACCO

Hansard Page: CA 23

Senator West asked:

(a) Could the Department provide for the Committee a copy of the NACCHO report into studies of attitudes about smoking?

(b) You said that it ($80 million for targeting indigenous communities, aimed at reducing smoking) would be targeting particular groups. Who is going to do that, and how is the targeting going to be undertaken?

(c) How much money is currently being spent on anti-tobacco programs for Aboriginal and Torres Strait Islander communities?

Answer:

(a) A copy of the NACCHO report into studies of attitudes about smoking is attached. **[Note: the report titled *Tobacco: time for action* has not been included in the electronic/printed volume]**

(b) On 31 May 2002 a $1 million package of measures was announced as an initial step in addressing tobacco usage in Indigenous communities and as a response to the report on indigenous smoking by the National Aboriginal Community Controlled Health Organisation (NACCHO).

The measures, which will be taken forward with advice from the National Expert Advisory Committee on Tobacco (NEACT) and specialist indigenous health advisers, are:

- An Aboriginal and Torres Strait Islander tobacco control clearinghouse, or centre of excellence. This initiative will be primarily web-based and will target all indigenous communities and those that work to promote health in these communities. It will support the collection and dissemination of information on, and the promotion and uptake of best practice in, Indigenous tobacco control. A suitable auspice for the clearinghouse, likely to be an academic or other non-government institution, will be selected by my Department following appropriate government purchasing guidelines.

- Strategies such as education and training aimed specifically at Aboriginal and Torres Strait Islander Health Workers to address the high smoking prevalence rate among this group as well as to develop the group's capacity to better support smoking cessation interventions in Indigenous communities. Tenders from specialists in public and indigenous health will be invited to develop, implement and evaluate these measures.

- Tobacco control health promotion and education resources to convey the risks associated with smoking and the pathways to quitting. These will be universally targeted to all indigenous communities and health workers and will be designed and delivered by specialists appointed via a tender process.

(c) It is not possible to state a figure that captures all the Commonwealth Government's expenditure on anti-tobacco programs for Aboriginal and Torres Strait Islander communities. Indigenous communities benefit from both targeted and general tobacco control measures funded by the Federal Government's $6.1 million contribution to the National Tobacco Strategy and the $19 million of Commonwealth funding that has been spent on the National Tobacco Campaign as at May 2002.

In addition, recent specifically targeted Indigenous anti-tobacco efforts include:

- Funding of $253,000 to NACCHO to work with Indigenous communities to assess community attitudes to smoking, appraise existing smoking cessation and health promotion programs, identify best practice and make recommendations to raise awareness of tobacco related harm and smoking cessation programs. This is additional to the $1 million set of initiatives (above).

- Additional funding of $1.2 million over four years for the Croc Festivals, announced in the 2002-03 Budget. This takes the existing Commonwealth commitments to the Croc Festivals to $1.5 million each year. The Croc Festivals were developed to encourage young Indigenous students to attend school more regularly and to lead healthy, positive lifestyles without misusing alcohol or consuming tobacco, illicit drugs or other volatile substances.

- Funding of $10,000 provided to the National Heart Foundation (Northern Territory Division) to evaluate a trial of nicotine replacement therapy as a smoking cessation aid for Aboriginal smokers in both urban and remote communities.

- Funding of $240,000 to Urbis Keys Young to produce a report on barriers that both the general population and various risk groups (including Indigenous people) face in accessing smoking cessation therapies. While Indigenous people were not the exclusive focus of this project, research was undertaken with Aboriginal and Torres Strait Islander people and the report specifically examined the barriers faced by Indigenous people when accessing smoking cessation therapies.

LIST OF COX IIs ON WHICH THE BUDGET 2002 “ENHANCEMENT OF PBS RESTRICTIONS” MEASURE IS BASED

Cox II's with Restrictions

PBS Codes	Drug name	Proprietry name	Dispensed Price for max. Qty $	Number of repeats	Drug Group	Restriction- used for the treatment of	Implementation	No. of Scripts 2000-2001	PBS costs 2000-2001
8439E	Celecoxib	celebrex	$32.05	3	Coxibs	**Symptomatic treatment of oesteoarthritis and Rheumatoid Arthritis**	2002-2003	418169	$11,036,760
8440F	Celecoxib	celebrex	$32.05	3	"	**"**	"	2894042	$149,517,879
8471W,	Rofecoxib	Vioxx	$29.44	3	"	**Symptomatic treatment of oesteoarthritis**	"	261574	$5,593,341
8472X,	Rofecoxib	Vioxx	$42.75	3	"	**"**	"	228469	$7,661,756
8473Y,	Rofecoxib	Vioxx	$29.44	3	"	**"**	"	307	$5,859
8474B	Rofecoxib	Vioxx	$42.75	3	"	**"**	"	242	$7,445
Totals								**3802803**	**$173,823,040**

LIST OF PROTON PUMP INHIBITORS ON WHICH THE BUDGET 2002 "ENHANCEMENT OF PBS RESTRICTIONS" MEASURE IS BASED

Protein Pump Inhibitors

PBS Codes	Drug name	Proprietry name	Dispensed Price for max. Qty $	No. of repeats	Drug Group	Restriction- used for the treatment of:	Implementation	No. of Scripts 2000-2001	PBS costs 2000-2001
2240X,	Lansoprazole	Zoton	$49.28	1	**Protein Pump Inhibitors**	Initial treatment of Peptic Ulcer	2002-2003	11228	$11,228
8528W,	"	"	$46.07	1	"	"	"		
8198L,	"	"	$30.90	5	"	Gastro-oesophageal reflux disease & scleroderma oesophagus	"	8682	$276,831
2241Y,	"	"	$49.28	5				578528	$35,775,521
8529X	"	"	$46.07	5	"	"	"		
1326T,	Omeprazole	Maxor	$46.11	5	"	Initial treatment of Peptic Ulcer	"	2689	$182,141
1327W,	"	"	$46.11	5	"	Gastro-oesophageal reflux, scleroderma oesophagus & Zollinger-Ellison syndrome	"	159793	$10,582,443
8331L,	Omeprazole Magnesium	Acimax Tabs Losec Tabs	$46.11	1	"	Treatment of peptic ulcer	"	41847	$2,722,022
8332M,	"	Losec	$29.47	5	"	Gastro-oesophageal reflux, scleroderma oesophagus & Zollinger-Ellison syndrome	"	11055	$369,102
8333N	"	Acimax Tabs Losec Tabs	$46.11 & $46.90	5	"	"	2002-2003	2313802	$147,509,222
8007K,	Pantoprazole Sodium Sesquihydrate	Somac	$48.42	1	"	Initial treatment of Peptic Ulcer	"	27623	$1,453,962
8399C,	"	"	$30.35	5	"	Gastro-oesophageal reflux,	"	9099	$252,198
8008L,	"	"	$48.42	5		"	"	366084	$20,889,251
8509W	Rabeprazole Sodium	Pariet	$46.11	1	"	Initial treatment of Peptic Ulcer	"	119	$6,264

8507R	"	"	$29.47	5	"	Gastro-oesophageal reflux, scleroderma oesophagus	"	13	$365
8508T	"	"	$46.11	5	"	"	"	984	$52,009
Totals								3531546	$220,082,559

NB Totals exclude 8528 & 8529 because they were PBS listed after 30 June 2001. They are included in the measure.

LIST OF SELECTIVE SEROTONIN REUPTAKE INHIBITORS ON WHICH THE BUDGET 2002 "ENHANCEMENT OF PBS RESTRICTIONS" MEASURE IS BASED

SSRIs with Restrictions

PBS Codes	Drug name	Proprietry name	Dispensed Price for maximum quantity $	Number of repeats	Drug Group	Restriction- used for the treatment of:	Implementation	No. of Scripts 2000-2001	PBS costs 2000-2001
8220P	Citalopram Hydrobromide	Cliazil,Talohexal & cipramil	$32.47 & $34.28	5	**Selective Seretonin Reuptake Inhibitors (SSRIs)**	**Major Depressive Disorders**	2003-2004	937,463	$27,739,648
8270G	Fluoxetine Hydrochloride	Lovan, Prozac	$33.98 & $38.08	5	"	**Major Depressive Disorders, Obsessive compulsive disorder**	"	110,251	$3,171,126
1434L	"	Auscap,Chemmart fluoxetine, fluohexal, fluoxetine-BC, GenRx fluoxetine, healthsense fluoxetine, lovan, Terry White fluoxetine, Zactin, Prozac	$33.98 & $38.08	5	"	"	"	659,779	$21,074,908
1809F	"	Lovan Liquid	$45.50	5	"	"	"	7,712	$314,802
8512B	Fluvoxemine Maleate	Luvox	$25.59	5	"	"	"	508	$7,557
8174F	"	Faverin100 & Luvox	$36.40 & $37.65	5	"	"	"	212,778	$6,997,614
2236Q	Sertraline Hydrochloride	Zoloft	$36.79	5	"	"	"	1,231,855	$33,776,195
2237R	"	"	$36.79	5	"	"	"	941,936	$28,756,969

2242B	Paroxetine Hydrochloride	Paxtine,Roxatine, Aropax	$35.92 & $36.41	5		**Major Depressive Disorders, Obsessive compulsive disorder & Panic disorder with or without agoraphobia**		1,273,217.00	$42,403,652
Totals								**5,375,499**	**$164,242,470**

LIST OF ANTI ASTHMA MEDICINES ON WHICH THE BUDGET 2002 "ENHANCEMENT OF PBS RESTRICTIONS" MEASURE IS BASED

Anti Asthma medications with restricitions

PBS Codes	Drug name	Proprietry name	Dispense Price for maximum quantity	Number of repeats	Drug Group	Restriction - used for the treatment of:	Implementation	No. of Scripts 2000-2001	PBS costs
8136F	Eformoterol Fumarate Dihydrate	Foradile	$35.14	5	**Andrenergics, inhalants**	**Patients with frequent episodes of asthma who are receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids**	2004-2005	92437	$2,842,926.64
8239P	"	Oxis Turbuhaler	$24.31	5	"	"	"	19378	$346,653.50
8240Q	"	"	$34.25	5	"	"	"	227873	$6,742,921.75
8354Q	Salbutamol Sulfate	Airomir Autohaler	$36.38	5	"	**Patients unable to achieve coordinated use of other metered dose inhalers containing this drug**	"	103833	$2,826,256.42
2000G	"	Asmol 2.5, Chem mart,GenRx,Health Sense & Terry White Chemists Salbutamols, PU, Ventolin Nebs	$24.00 & $26.20	5	"	**Asthma or COPD where treatment with this drug delivered from an oral pressurised inhalation device via a large volume spacer is inappropriate**	"	191133	$3,042,810.66
2001H	"	"	$25.12 &$27.32	5	"	"	"	747792	$15,866,914.59
2003K	"	Pu & Ventolin	$11.48 & $13.50	2	"	"	"	5036	$51,345.00
3027H	Salmeterol Xinafoate	Serevant	$34.25	5	"	**Patients with frequent episodes of asthma who are receiving treatment with oral corticosteroids or optimal doses of inhaled corticosteroids**	"	437980	$12,944,249.99
8141L	"	Serevant Accuhaler	$34.25	5	"	"	"	130854	$3,904,662.63

1251W	Terbutaline Sulfate	Bricanyl Respules	$26.70	5	"	**Asthma or COPD where treatment with this drug delivered from an oral pressurised inhalation device via a large volume spacer is inappropriate**	"	8430	$193,489.92
1243K	"	Bricanyl	$10.77	5	"	"	"	706	$7,207.40
8517G	Fluticasone Propionate with Salmeterol Xinafoate	Seritide MDI 50/25	$45.82	5	**Andrenergics and other drugs for obstructive Airway Diseases**	**Patients who previously had frequent episodes of asthma while receiving t'ment with oral corticosteroids or optimal doses of inhaled corticosteroids and who are stabilised on concomitant inhaled salmeterol xinafoate and fluticasone propionate**	2004-2005	631	$21,452.50
8518H	"	Seritide MDI 125/25	$59.24	5	"		"	1631	$77,350.47
8519J	"	Seritide MDI 250/25	$79.38	5	"	"	"	5636	$391,153.11
8430Q	"	Seritide Accuhaler 100/50	$45.82	5	"	"	"	46330	$1,620,615.53
8431R	"	Seritide Accuhaler 250/50	$59.24	5	"	"	"	301574	$14,976,664.12
8432T	"	Seritide Accuhaler 500/50	$79.38	5	"	"	"	393622	$28,182,382.65
8142M	Beclomethasone Dipropionate	Respocort 50 Autohaler	$20.00	5	"	**Patients unable to achieve co-ordinated use of other metered dose inhalers containing this drug**	"	224	$3,767.00
8143N	"	Respocort 100 Autohaler	$25.79	5	"	"	"	5319	$89,246.00
8237M	"	Respocort 250 Autohaler	$36.91	5	"	"	"	13091	$386,634.20
8408M	"	Qvar 50 Autohaler	$25.79	5	"	"	"	4408	$69,295.09
8409N	"	Oral Pressurised inhalation 100	$36.91	5	"	"	"	31266	$877,983.07

8279R	Ipratropium Bromide	Atrovent Autohaler	$52.98	5	"	"	"	35091	$1,537,232.73
1542E	"	Apoven 250, Chem mart Ipratropium, DBL Ipratropium, GenRx Ipratropium,Health Sense Ipratropium, Ipratrin, Ipravent, Terry White chemists, Ipratropium, Atrovent,	$52.50 & $52.98	5	"	**Asthma or COPD where treatment with this drug delivered from an oral pressurised inhalation device via a large volume spacer is inappropriate**	"	125400	$5,723,737.45
8238N	"	Atrovent, Ipratin Adult, Ipravent	, $61.20 & $61.78	5	"	"	"	541702	$31,764,497.20
1541D	"	Atrovent	$18.44	2	"	"	"	4214	$82,432.76
Totals								**3,475,591**	**$134,573,882.38**

Measures as a percentage of total PBS Volume and costs to Government 2000-2001

	Script Vol	Cost to Gov	total
Cox II's	3,802,803	173,823,040	
PPI's	3,531,546	220,082,559	
SSRI's	5,375,499	164,242,470	
Anti Asthma	3,475,591	134,573,882	

			Rough workings
Restriction totals	52,420,703	1,616,043,218	36%
PBS Totals	147,571,358	3,810,216,018	42%

Membership and expertise of the Pharmaceutical Health And Rational use of Medicines (PHARM) Committee

Professor Ric Day (Chair) – Clinical Pharmacology

Associate Professor Andrew Gilbert – Behavioural Science/pharmacy

Mr Tony Wade – Consumer issues

Ms Roberta Lauchlan – Pharmacy/Private Health Services

Ms Denise Fry – Health Education

Professor Helen Baker – Nursing

Professor Sue Tett – Pharmacy

Ms Sarah Fogg – Consumer issues

Dr Gregory Pearce – Pharmaceutical industry

Dr Libby Roughead – Generalist in QUM

Dr Alex Hope – General Practice

[updated PHARM membership and expertise list provided by DoHA, 17 July 02]

APMA Australian Pharmaceutical Manufacturers Association Inc. ABN 57 105 606 803

Mr Alan H. Evans
Chief Executive Officer

Mr. Allan Rennie
Assistant Secretary
Pharmaceutical Access and Quality Branch
Department of Health and Ageing
Alexandra Building
Furzer St
Phillip ACT 2606

Dear Allan,

Further to our recent discussions regarding the measure announced in the Budget whereby the APMA undertook to ensure that the PBS indications would be communicated to Medical Practitioners by a variety means, I wish to advise you of the steps taken to date to give effect to the commitment and also suggest means whereby we could jointly assess the introduction and effect of the measures.

Firstly we are in the final stages of drafting the changes to the Code of Conduct which will be put to our Board for ratification. The changes will specify both that it is a requirement that in both in advertisements and marketing material for pharmaceutical products the PBS indications should be displayed in such material. The Code will specify the size, prominence and type size of such information in the marketing material. I can assure you that we are intent on ensuring that such information is not "buried" within the material. Indeed we want to ensure that Medical Practitioners viewing the material readily notice the information.

We will also make it a requirement in the Code of Conduct that Mecical Representatives visiting Medical Practitioners inform then of the PBS indications.

Additionally we are presently preparing material for inclusion in a module, which will be part of the CEP Course for Pharmaceutical Industry Medical Representatives conducted for the APMA by Deakin University. I expect that the module will be introduced into the course in the final semester this year. It is a requirement that all Medical Representatives complete this course.

As you will appreciate this is a significant commitment by the Pharmaceutical Industry and given that there are approximately 3000 Medical Representatives employed by the industry it will provide a source of advice and information of some substance and comprehensiveness to Medical Practitioners as to what are the PBS indications of pharmaceuticals. Whilst it ahs been normal practice in the past for many of our member companies to do provide advice on the PBS indications of products, the changes we are enacting will ensure that the extent of the advice to Medical Practitioners will be quite extensive.

A matter which I would like to discuss with you is how we can jointly assess the extent of knowledge of PBS indications presently held by Medical Practitioners and the effect of the actions by the industry to better inform Medical Practitioners of PBS indications. We then consider after a period of time (say 12 months) the impact of the actions by the industry

We might wish to jointly consider benchmarking the presen: extent of knowledge and the source of information Medical Practitioners utilise for information as to what are the PBS indications of products and then after a period of time assess the effect of the industry's activities on extending Medical Practitioners knowledge of PBS indications.

I would suggest that when we have finalised the changes to the Code of Conduct we forward them to you and then meet to further discuss their implementation and also the steps we might collectively take assess their impact.

Yours sincerely

Alan H Evans
Chief Executive Officer

31 May 2002

Australian Institute for Primary Care final report *Evaluation of the National Prescribing Service in achieving savings to the Pharmaceutical Benefits Scheme*, Feb. 2001

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

MEDICAL INDEMNITY FORUM, 23 APRIL 2002

FRONT TABLE		
Coonan	Helen	Minister for Revenue and Assistant Treasurer
Govey	Ian	For Attorney-General
Patterson	Kay	Minister for Health and Ageing
MINISTER'S TABLE		
Aagaard	Jane	NT Minister for Health and Community Services
Edmond	Wendy	QLD Minister for Health
Jackson	Judy	TAS Minister for Health and Human Services
Knowles	Craig	NSW Minister for Health
Kucera	Robert	WA Minister for Health
Stanhope	Jon	ACT Chief Minister and Minister for Health
Stevens	Lea	SA Minister for Health
Thwaite	John	Victorian Minister for Health
MAIN TABLE		
Abbott	Tony	Law Council of Australia
Anderson	Mandy	Medical Defence Association South Australia
Atkins	Geoff	Trowbridge Consulting
Bain	Robert	Australian Medical Association
Ballenden	Nicola	Australian Consumers' Association
Barraclough	Bruce	Australian Council on Quality and Safety in Health Care
Beh	Helen	Australian Orthopaedic Association
Birtles	Sue	Department of Education and Community Services
Birtwhistle	Ian	Macquarie Underwriting
Brown	Ian	Insurance Australia Group (NRMA)
Burstow	Paul	Medical Indemnity Victoria MDV Insurance Brokers
Burton	Pamela	Australian Medical Association
Campbell	John	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Campbell	Jane	Structured Settlements Working Group

Clark	Steve	Australian Divisions of General Practice
Cooke	Robert	Mayne
Cormack	Mark	Australian Healthcare Association
Cornwell	Amanda	Public Interest Advocacy Centre
Cowie	Marita	Australian College of Rural and Remote Medicine
Cuff	Chris	Trowbridge Consulting
Curran	Lynn	Department of the Treasury
Curran	Brian	Rural Doctors Association of Australia
Davis	Rob	Australian Plaintiff Lawyers Association
Dickens	Robert	Queensland Doctors' Mutual
Dix	Andrew	Australian Medical Council
Faulkner	Kingsley	Royal Australasian College of Surgeons
Furler	Liz	Royal College of General Practitioners
Gorman	David	Royal Australasian College of Physicians
Gregory	Gordon	National Rural Health Alliance
Gregory	Penny	ACT Health
Hemming	Paul	Royal College of General Practitioners
Hicks	Henry	Australian Association of Surgeons
Hollands	Michael	Royal Australasian College of Surgeons
Hopkins	Helen	Consumer Health Forum
Johnston	Penny	Medical Defence Association Western Australia INC
Lee	Audrey	Insurance Council of Australia
Long	Eleanor	Royal Australian and New Zealand College of Obstetricians and Gynaecologists
Mackey	Ken	Rural Doctors Association of Australia
Madden	Bill	Australian Plaintiff Lawyers Association
Martin	Peter	Department of the Treasury
Maskell-Knight	Charles	Department of Health and Ageing
Mason	Alan	Insurance Council of Australia
Massaro	Vin	Royal Australasian College of Surgeons
McLeod	Mike	United Medical Protection
Milgate	Stephen	Council of Procedural Specialists
Morauta	Louise	Department of Health and Ageing
Mortimer	Robin	Royal Australasian College of Physicians
Neave	Marcia	Victorian Law Reform Commission
Nisselle	Paul	Medical Indemnity Protection Society

Phelps	Kerryn	Australian Medical Association
Phillips	Jonathon	Committee of Presidents of Medical Colleges
Roberts	Darryl	Australian Prudential Regulation Authority
Roff	Michael	Australian Private Hospitals Association
Rogers	Graham	Institute of Actuaries of Australia
Schneider	Russell	Australian Health Insurance Association
Sedgeley	Michael	Australian Medical Association
Sheldon	Don	Council of Procedural Specialists
Skene	Loane	The University of Melbourne
Smallwood	Richard	Department of Health and Ageing
Stable	Robert	Queensland Health
Sullivan	Francis	Catholic Health Care Australia
Symons	Nigel	Australian Society of Anaesthetists
Tangney	Maureen	Attorney-General's Department
Thompson	Julie	Australian Divisions of General Practice Central West Gippsland
Tito	Fiona	Consultant, Enduring Solutions
Tongue	Andrew	Department of Transport and Regional Services
Turner	William	Medical Protection Society of Tasmania
Valena	Mark	Medical Defence Association Victoria
Vonau	Marianne	Neurosurgical Society of Australasia
Watson	David	Medical Defence Association Western Australia INC
Weedon	David	Royal College of Pathologists of Australasia
Wilding	Kalev	Australian Orthopaedic Association
Wronski	Ian	Australian College of Rural and Remote Medicine

National Prescribing Service literature for medical practitioners re overuse of antibiotics

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

National Drug Strategy: *Alcohol in Australia: issues and strategies*; Plan for Action 2001 to 2003-04, July 2001

The documents are accessible at the following website:
http://www.nationaldrugstrategy.gov.au/resources/publist.htm

Commonwealth Department of Health and Ageing

Health Access and Financing Division
GPO Box 9848, Canberra ACT 2601
Telephone: (02) 6289 8373 Fax: (02) 6289 8641
ABN 83 605 426 759

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

Dear Senator Knowles

Pharmaceutical Benefits Scheme Budget Brochure Distribution

I am writing to provide amended information in relation to the response offered by the Department to a question from Senator McLucas during the Budget Estimates hearings of the Senate Community Affairs Legislation Committee on Thursday 6 June 2002 (Hansard page CA 281). Senator McLucas asked when the Pharmaceutical Benefits Scheme (PBS) Budget Brochure was distributed.

In response, the Department advised that the brochure had been sent out shortly after the Federal Budget.

In fact, although the process was commenced shortly after the Budget, it took some time to complete. The mailing house has advised that the mail out commenced on Wednesday 22 May 2002 and was completed on Thursday 6 June 2002.

Yours sincerely

Charles Maskell-Knight
A/g First Assistant Secretary
Health Access and Financing Division
20 June 2002

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-008

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICARE STATISTICS ON PREGNANCY TERMINATION

Written Question on Notice

Senator Harradine asked:

Please provide Medicare statistics on abortion for the last financial year (or the months since 30 June which have been processed to date).

Answer:

Tables showing the number of services and benefits paid, by item number and by the State/Territory in which services were rendered in the period 1984/85 to 2000/01 and the nine months to March 2001 and 2002, are attached as Tables 1a, 1b, 1c and 1d. Tables showing the number of services and benefits paid, by item number and Patient State/Territory in the period 1984/85 to 2000/01 and the nine months to March 2001 and 2002, are attached as Tables 2a, 2b, 2c and 2d

The definitions of medical services included in the Schedule to the Health Insurance Act which may result in the termination of pregnancy appear in the Medicare Benefits Schedule as follows:

- ITEM 16525
  MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction, for intrauterine foetal death, gross foetal abnormality or life threatening maternal disease, not being a service to which item 35643 applies (effective from 1 November 1995). Prior to 1 November 1995, the relevant item was Item 274/5, 16545/6 - MANAGEMENT OF SECOND TRIMESTER LABOUR, with or without induction

- ITEM 35643
  EVACUATION OF THE CONTENTS OF THE GRAVID UTERUS BY CURETTAGE OR SUCTION CURETTAGE not being a service to which item 35639/35640 applies, including procedures to which item 35626, 35627 OR 35630 applies, where performed.

The attached data only relates to services rendered on a ‘fee-for-service’ basis for which Medicare benefits were paid. Excluded are details of services to public patients in hospital and through other publicly funded programs.

Attachment E02-008

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING
Table 1a: Incidence of Items 16525 (274/5,16545/6)(a), 1984/85 to end Mar 2002
(Date of Processing - State Service Rendered)

Year	*NSW* (c)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT/NT*(b)	*AUST*
1984/85	167	204	38	76	60	12	15	572
1985/86	184	184	73	78	53	10	21	603
1986/87	185	171	62	61	45	10	21	555
1987/88	204	190	102	72	67	17	22	674
1988/89	222	217	78	65	49	11	18	660
1989/90	223	308	95	45	124	14	31	840
1990/91	264	285	102	62	196	13	29	951
1991/92	266	313	113	60	157	19	22	950
1992/93	256	284	113	82	177	21	25	958
1993/94	261	297	143	63	172	7	26	969
1994/95	240	312	188	61	191	11	29	1032
1995/96	237	223	164	49	119	13	21	826
1996/97	225	172	115	53	62	16	12	655
1997/98	209	164	116	55	63	10	22	639
1998/99	187	158	119	54	48	22	9	597
1999/00	201	208	106	57	46	16	11	645
2000/01	200	247	125	55	45	10	10	692
2000 Jul-2001 Mar	151	177	88	43	33	6	7	505
2001 Jul-2002 Mar	145	171	75	41	30	6	5	473

(a) Management of second trimester labour.
(b) ACT and NT data are not separately available.
(c) Includes a small number of services rendered overseas in the early years of Medicare.
(d) Not published due to small number of services

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING

Table 1b: Incidence of Item 35643 (6469)(a), 1984/85 to end Mar 2002

(Date of Processing - State Service Rendered)

Year	*NSW* (b)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*AUST*
1984/85	28117	14075	4644	1617	6148	363	85	104	55153
1985/86	29398	14534	4567	1536	6398	436	92	91	57052
1986/87	30375	16349	5159	1638	7011	409	128	96	61165
1987/88	29080	16190	6979	1480	6753	443	118	88	61131
1988/89	28847	17360	8639	1538	7039	365	95	112	63995
1989/90	31355	18895	8688	1620	7422	418	98	144	68640
1990/91	31972	19508	7733	1767	7632	366	97	171	69246
1991/92	33301	19756	9060	1739	7711	614	97	200	72478
1992/93	33029	19857	9969	1176	8078	787	112	266	73274
1993/94	34206	20526	10393	1189	8306	849	108	256	75833
1994/95	34951 (c)	20248	11775	972	8331	754	(d)	186	77217
1995/96	35221 (c)	20118	11756	777	8775	743	(d)	161	77551
1996/97	34407 (c)	20133	11784	632	8383	699	(d)	153	76191
1997/98	33918 (c)	19384	11937	601	8278	639	(d)	157	74914
1998/99	34287 (c)	19379	11908	533	7696	591	(d)	99	74493
1999/00	34131 (c)	18729	12544	580	7124	481	(d)	110	73699
2000/01	35150 (c)	18982	13081	546	7552	492	(d)	108	75911
2000 Jul- 2001 Mar	26968 (c)	14420	9900	398	5853	400	(d)	86	58025
2001 Jul- 2002 Mar	27399 (c)	13813	9874	501	6106	299	(d)	111	58103

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.

(b) Includes a small number of services rendered overseas in the early years of Medicare.

(c) Includes data for ACT. See footnote (d)

(d) Separate data not available. Included in NSW.

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING

Table 1c: Benefits Paid for Items 16525 (274/5,16545/6)(a), 1984/85 to end Mar 2002

(Date of Processing - State Service Rendered)

$

Year	*NSW* (c)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT/NT*(b)	*AUST*
1984/85	23328	28406	4673	10954	8251	1536	2074	79222
1985/86	26950	27327	10638	11758	7862	1514	2282	88330
1986/87	26262	24487	8894	8956	6495	1429	3042	79565
1987/88	26044	23978	13047	8912	8436	1750	2890	85054
1988/89	27210	27687	9840	8274	6017	1436	2366	82829
1989/90	29549	40839	12386	6206	15286	1695	4081	110040
1990/91	37398	39736	14060	8954	26207	1866	4217	132438
1991/92	39251	46176	16709	9007	22242	2874	3231	139490
1992/93	39733	44112	17540	12827	25790	3279	3881	147163
1993/94	40913	46654	21885	9985	25418	1105	4071	150031
1994/95	38432	49560	30496	9697	32114	1745	4692	166736
1995/96	38390	36102	27235	7899	20357	2108	3410	135502
1996/97	36584	27908	18646	8631	10118	2627	2001	106515
1997/98	34451	26926	19097	9058	10380	1621	3616	105148
1998/99	31325	26312	19826	9013	8014	3660	1550	99700
1999/00	34027	35365	18029	9654	7765	2712	1864	109416
2000/01	34368	42079	21551	9503	7737	1716	1714	118667
2000 Jul-2001 Mar	25913	30052	15186	7431	5667	1026	1196	86471
2001 Jul-2002 Mar	25121	29619	13010	6988	5147	1041	874	81801

(a) Management of second trimester labour.

(b) ACT and NT data are not separately available.

(c) Includes a small number of services rendered overseas in the early years of Medicare.

(d) Not published due to small number of services

COMMONWEALTH DEPARTMENT OF HEALTH AND AGEING

Table 1d: Benefits Paid for Item 35643 (6469)(a), 1984/85 to end Mar 2002

(Date of Processing - State Service Rendered)

Year	*NSW* (b)	*VIC*	*QLD*	*SA*	*WA*	*TAS*	*ACT*	*NT*	*AUST*
1984/85	2983968	1481716	492474	162710	654638	34664	8168	10415	5828753
1985/86	3241794	1586504	502184	162064	708062	45341	9076	9545	6264570
1986/87	3210170	1713654	543101	167630	743451	41115	12849	9935	6441906
1987/88	3011061	1662215	729780	135446	704960	40912	10508	8160	6303043
1988/89	3073975	1833065	933946	141997	757682	33498	8194	10356	6792712
1989/90	3537717	2105921	991065	159014	847090	39430	9374	14271	7703882
1990/91	3790067	2287863	919920	182339	915962	36252	9461	18136	8159999
1991/92	4079041	2377944	1108347	186401	954765	68703	9951	21941	8807095
1992/93	4117395	2458153	1261425	128715	1031763	94662	11816	29524	9133454
1993/94	4207953	2581966	1335344	131644	1077729	105692	11327	29384	9481040
1994/95	4382311 (c)	2577686	1527164	110044	1093690	95249	(d)	21683	9807828
1995/96	4498206 (c)	2591740	1551337	88903	1170550	94849	(d)	18572	10014157
1996/97	4426255 (c)	2611460	1563180	72324	1124500	89035	(d)	17522	9904276
1997/98	4426325 (c)	2546568	1598043	69991	1123577	83238	(d)	18597	9866339
1998/99	4566754 (c)	2568566	1622204	63685	1060561	77984	(d)	11595	9971349
1999/00	4630501 (c)	2465059	1741477	69283	996291	64397	(d)	13245	9980252
2000/01	4839114 (c)	2500398	1839502	66332	1069126	65029	(d)	13156	10392657
2000 Jul-2001 Mar	3708225 (c)	1896967	1390241	48099	828100	53474	(d)	10545	7935652
2001 Jul-2002 Mar	3687864 (c)	1805679	1408702	62007	868996	39134	(d)	13788	8024398

(a) Evacuation of the contents of the gravid uterus by curettage or suction curettage.

(b) Includes a small number of services rendered overseas in the early years of Medicare.

(c) Includes data for the ACT. See footnote (d).

(d) Separate data not available. Included in NSW.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-009

OUTCOME 2: ACCESS TO MEDICARE

Topic: HIC FRAUD CONTROL PLAN

Written Question on Notice

Senator Harradine asked:

In answer to question E02000135 (a) you provided a copy of the summary of the HIC's Fraud Control Plan and indicated that a new plan had been commissioned. Please provide me with a full copy of the new plan or if that plan is not yet available, a full copy of the current plan.

Answer:

The HIC's Fraud Control Plan is due to be finalised in July 2002 and is not yet available. HIC will provide you with a copy once it is completed. The current HIC's Fraud Control Policy we provided previously to the Senate Community Affairs Legislation Committee in February 2002 is still current.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-010

OUTCOME 2: ACCESS TO MEDICARE

Topic: INVESTIGATION OF ABORTION PROVIDERS

Written Question on Notice

Senator Harradine asked:

In answer to question E02000135 (c) you noted that there had been investigations of providers of abortion who had been suspected of breach of the rules relating to bulk billing and illegal charging of additional fees to patients. Would you please provide me with further details of these investigations including copies of any reports or documentation produced on the outcomes of the investigations.

Answer:

HIC investigated a complaint that an additional fee had been charged in association with a direct-billed service. Subsequent investigation showed that the complaint was unfounded. HIC is unable to provide copies of the report, as this would constitute a breach of privacy.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-011

OUTCOME 2: ACCESS TO MEDICARE

Topic: PROCESS OF RANDOM CHECKING OF CLAIMS

Written Question on Notice

Senator Harradine asked:

In answer to question E02000135 (d) you state that there have not been any abortion providers audited by the HIC over the past five years. Would you please explain to me the process by which claims for abortion and other items of the MBS are randomly checked to ensure that they are valid claims.

Answer:

On-going random audits of MBS items are conducted following the process outlined below:

- State based audit staff randomly select providers from completed work processed by Claims Processing Centres. For each selected provider a number of claims is randomly drawn. Providers who have been previously selected within the preceding 18 months are rejected.

- Audit staff validate the selected claims through examination of the claim form (to look for data inconsistencies and unauthorised alterations) and through confirmation of claim details with the providers.

- Where audit staff detect inconsistencies with the claim, the patient/provider is contacted and given the opportunity to clarify, or provide additional, information.

- Where errors in claiming are confirmed, recovery action is initiated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-012

OUTCOME 2: ACCESS TO MEDICARE

Topic: RANDOM CHECKS OF SERVICE PROVIDERS

Written Questions on Notice

Senator Harradine asked:

Has the HIC undertaken any random checks of service providers claiming for MBS items 16525 or 35643 in the past five years? If so, can I please have a copy of any report or documentation on the outcome of those checks.

Answer:

No, the MBS items 16525 or 35643 have not as yet appeared in random selections to date. Over time, it could be anticipated that they would appear as part of the random audit process, although given the size of the Medicare program, and the numbers of claims processed by HIC on an annual basis, the likelihood of these particular items being selected for audit is extremely remote.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-013

OUTCOME 2: ACCESS TO MEDICARE

Topic: TOP TWENTY SERVICE PROVIDERS FOR MBS ITEM 16525

Written Question on Notice

Senator Harradine asked:

Would you please provide me with a table listing the (a) the total dollar amount, (b) the number of paid claims and (c) the state or territory for each of the top twenty service providers for MBS item 16525 in the calender year 2001.

Answer:

Please refer to the following table.

Item 16525

	NSW/ACT	**VIC/TAS**	**QLD**	**SA/NT**	**WA**	**AUSTRALIA**
No. Claims	232	254	116	69	43	714
$ Benefit	40,043	43,691	20,069	11,815	7,368	122,986

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

OUTCOME 2: ACCESS TO MEDICARE Question: E02-014

Topic: TOP TWENTY SERVICE PROVIDERS FOR MBS ITEM 35643

Written Question on Notice

Senator Harradine asked:

Would you please provide me with a table listing the (a) the total dollar amount, (b) the number of paid claims and (c) the state or territory for each of the top twenty service providers for MBS item 35643 in the calender year 2001.

Answer:

Please refer to the following table.

Item 35643

	NSW/ACT	**VIC/TAS**	**QLD**	**SA/NT**	**WA**	**AUSTRALIA**
No. Claims	33,624	19,031	14,861	1,015	7,801	76,332
$ Benefit	4,649,589	2,510,740	2,109,489	128,699	1,104,768	10,503,285

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-016

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL RECORDS OF CHILDREN

Written Question on Notice

Senator Harradine asked:

Has the HIC responded to concerns from medical groups about children as young as 12 being able to keep their medical records a secret from their parents? (The Age, May 9, 2002)

Answer:

Yes. HIC responded to comments by the Australian Medical Association in both the general and medical media.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-017

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL RECORDS OF CHILDREN

Written Question on Notice

Senator Harradine asked:

(a) Parents must have the consent of children aged 12 or older to obtain information about their Medicare records. How did the HIC originally arrive at age of 12 for them to have privacy in regard to medical records?
(b) Is the HIC reviewing this policy?
(c) Has the HIC received complaints from parents about the policy?

Answer:

(a) The age 12 practice was based originally on case law – specifically Secretary, Department of Health and Community Services v JWB ((Marion's Case) (1992) 175 CLR).

(b) HIC is not currently reviewing this policy, however, the Attorney-General's Consultative Group on Children's Privacy was established by the Attorney-General in June 2001 to review existing Commonwealth privacy laws and to consider whether there is a need for more specific protection of children's personal information. This Consultative Group will shortly release a Consultation Draft for public comment. The process will enable input from other interested Government Agencies and may lead to a recommendation for new laws in relation to the privacy of children. HIC will contribute advice to this process.

(c) Yes, although very few complaints have been received during the decade that this policy has been in place.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-018

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL RECORDS OF CHILDREN

Written Question on Notice

Senator Harradine asked:

Could the HIC inform the committee of the main categories of treatment requiring secrecy from parents for children as young as 12?

Answer:

HIC is bound by legislation to protect the secrecy of all personal information it holds.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-051

OUTCOME 2: ACCESS TO MEDICARE

Topic: PET SCANNERS

Written Question on Notice

Senator Denman asked:

A response to a question from February Additional Estimates, indicated that there are currently 7 publicly funded machines (Tasmania excluded).

(a) What provisions/assistance is provided to Tasmanian patients needing a P.E.T scan and presumably needing to travel to Melbourne to receive it?
(b) Could you please indicate the average waiting time for a publicly funded P.E.T scan, and also, the average time for a Tasmanian waiting to have a P.E.T scan?

Answer:

(a) The Patient Travel Assistance Scheme (PTAS) funded by the Tasmanian Government entitles Tasmanian residents who are required to travel interstate for a specialist medical service not available in Tasmania, to financial assistance with travel, accommodation and escort costs, where required. Positron Emission Tomography (PET) is an eligible service under the PTAS scheme, and a requirement is for patients to be referred to the nearest appropriate specialist, being Melbourne. The Director of the Department of Medical Imaging at the Royal Hobart Hospital is responsible for approving applications for interstate referrals for PET scans throughout Tasmania.

(b) Waiting times at publicly funded PET facilities vary from several days at newer facilities such as that at the Royal Adelaide Hospital, to three to four weeks (or ten days for urgent cases) at longer established facilities like the Peter MacCallum Cancer Institute (Victoria) and the Royal Price Alfred Hospital (New South Wales).

Tasmanian patients requiring PET scans are referred to either the Peter MacCallum Cancer Institute or Austin and Repatriation Medical Centre, both located in Melbourne. Waiting times are as for other patients:

- Peter MacCallum Cancer Institute: three to four weeks normally, or ten days for urgent cases.
- Austin and Repatriation Medical Centre: two to three weeks normally, or seven to ten days for urgent cases.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-019

OUTCOME 2: ACCESS TO MEDICARE

Topic: MRS NANCY CRICK

Written Question on Notice

Senator Harradine asked:

(a) Is the Department aware whether Dr Philip Nitschke or any other doctor claimed on Medicare for appointments with Nancy Crick?
(b) What would be the process for establishing whether Dr Nitschke or any other doctor was providing advice contrary to the law of Queensland?

Answer:

(a) No.

(b) Questions relating to the lawful practice of medicine in Queensland are a matter for that State. The Medical Board of Queensland is the authority responsible for investigating such matters on behalf of the State.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-020

OUTCOME 2: ACCESS TO MEDICARE

Topic: NANCY CRICK/DR NITSCHKE

Written Question

Senator Harradine asked:

If Dr Nitschke or any other doctor were to be investigated by the Queensland Police and Medical Board for his role in Nancy Crick's death, would that affect his status with Medicare?

Answer:

Doctors are eligible to claim under the Medicare Benefits Scheme provided they are currently registered medical practitioners in their State or Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-021

OUTCOME 2: ACCESS TO MEDICARE

Topic: ASSISTED SUICIDE

Written Question on Notice

Senator Harradine asked:

Does the Department consider assisted suicide a “clinically relevant service”?

Answer:

No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-022

OUTCOME 2: ACCESS TO MEDICARE

Topic: MBS PAYMENTS FOR LATE TERM ABORTIONS

Written Question on Notice

Senator Harradine asked:

With regard to the Medicare Benefits Schedule (MBS) payments for late-term abortion, does the MBS cover inductions for suspected “abnormality”, in the second and third trimester?

Answer:

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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-015

OUTCOME 2: ACCESS TO MEDICARE

Topic: ANALYSIS OF IVF TREATMENT CYCLES

Written Question on Notice

Senator Harradine asked:

In answer to question E01000036, regarding costs for the unlimited Medicare covered IVF treatment cycles, the Department responded that it would be "Undertaking a detailed analysis to determine expenditure in respect of treatment cycles beyond 6 once there is 12 months' data available." Has the detailed analysis been undertaken and, if so, is this information now available?

Answer:

An analysis of the data has now been undertaken.

Based on a sample of Medicare benefits data covering the 12 months period ended 31 October 2000 as compared with the 12 months ended 31 October 2001, removal of the 6 cycle restriction on IVF services is estimated to have cost $0.7 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-185

OUTCOME 2: ACCESS TO MEDICARE

Topic: BULK BILLING UNDER MEDICARE

Written Question on Notice

Senator McLucas asked:

(a) Please provide the rates of bulk billing for 2001-02
(b) Please provide the rates of bulk billing by GP's for 2001-02
(c) Please provide the rates of bulk billing for 2001-02 for Federal Electoral Divisions
(d) Please provide the rates of bulk billing by GP's for the last three years by Federal Electoral Division

Answer:

(a) In the 12 months ending March 2002, 70.7 per cent of all services under Medicare were bulk billed.

(b) In the 12 months ending March 2002, 75.7 per cent of unreferred (GP) attendances were bulk billed.

(c) Statistics on rates of bulk billing by Federal Electoral Division for the 12 months ending March 2002 are at Attachment 1.

(d) Statistics on rates of bulk billing by Federal Electoral Division for unreferred (GP) attendances for the 12 months ending March 2000, 2001 and 2002, are at Attachment 2.

Notes:

The statistics relate to services rendered on a 'fee-for-service' basis for which Medicare benefits were processed by the Health Insurance Commission in the periods in question.

Medicare statistics are captured at the postcode level. Since some postcodes overlap Federal Electoral Division boundaries, statistics by Medicare enrolment postcode were mapped to electorate using data from the Census of Population and Housing showing the proportion of the population of each postcode in each electoral division.

Attachment 2 E02-185

Medicare - unreferred (GP) attendances bulk billed by Federal Electoral Division for 12 months ending March 2000, March 2001 and March 2002 (period of processing)

Federal	Percentage Bulk Billed		
Electorate	March 2000	March 2001	March 2002
Adelaide	81.3	83.3	79.3
Aston	85.7	85.7	84.1
Ballarat	66.7	64.9	62.5
Banks	87.5	87.5	87.1
Barker	43.2	43.6	43.1
Barton	92.7	92.8	92.7
Bass	53.5	51.7	50.3
Batman	92.8	92.1	90.1
Bendigo	53.0	50.7	48.9
Bennelong	82.5	82.4	82.5
Berowra	77.5	77.2	76.4
Blair	83.7	82.7	80.1
Blaxland	96.1	96.4	96.5
Bonython	93.4	93.4	91.6
Boothby	67.7	65.9	64.8
Bowman	87.5	85.7	82.9
Braddon	67.5	65.7	63.7
Bradfield	68.5	67.7	66.5
Brand	82.9	79.1	69.5
Brisbane	87.2	84.9	79.5
Bruce	86.3	85.5	82.5
Burke	71.2	71.7	70.8
Calare	61.3	61.2	60.9
Calwell	94.5	93.5	91.5
Canberra	60.3	57.2	52.4
Canning	71.4	69.6	66.4
Capricornia	46.0	45.9	49.1
Casey	75.9	76.2	74.1
Charlton	78.6	76.4	66.8
Chifley	98.6	98.6	98.5
Chisholm	84.1	82.7	80.4
Cook	81.3	80.6	79.7
Corangamite	58.3	53.5	48.9
Corio	70.1	67.5	63.1
Cowan	89.2	87.4	82.6
Cowper	53.3	54.6	54.0
Cunningham	85.0	85.4	85.5
Curtin	64.7	63.9	62.5
Dawson	56.7	59.3	65.5
Deakin	80.6	79.6	77.4
Denison	58.9	59.3	57.7
Dickson	79.6	77.3	69.5
Dobell	86.8	80.0	71.6
Dunkley	78.4	78.4	67.6

Eden-Monaro	44.7	42.1	41.7	
Fadden	88.2	87.2	83.6	
Fairfax	80.0	77.3	73.4	
Farrer	46.4	45.7	43.4	
Fisher	91.1	88.8	86.5	
Flinders	71.3	69.3	56.4	
Forde	91.0	90.6	88.4	
Forrest	52.4	53.1	52.6	
Fowler	98.2	98.3	98.3	
Franklin	58.8	58.7	56.3	
Fraser	67.7	63.8	56.0	
Fremantle	82.7	81.2	77.8	
Gellibrand	94.3	93.8	92.2	
Gilmore	66.3	65.1	64.5	
Gippsland	54.4	54.7	55.0	
Goldstein	73.2	71.1	65.1	
Grayndler	95.1	94.8	93.7	
Greenway	95.6	95.4	95.3	
Grey	67.2	67.7	67.6	
Griffith	88.6	87.4	81.2	
Groom	73.1	71.6	68.4	
Gwydir	62.7	61.1	61.7	
Hasluck	81.8	81.0	77.4	
Herbert	70.1	64.7	59.1	
Higgins	75.5	72.6	68.4	
Hindmarsh	76.3	75.9	75.4	
Hinkler	42.1	39.6	42.7	
Holt	91.7	90.4	85.4	
Hotham	88.3	86.6	84.3	
Hughes	80.4	79.9	79.5	
Hume	60.5	61.0	61.2	
Hunter	58.7	57.7	54.4	
Indi	42.6	41.2	41.1	
Isaacs	85.4	84.6	79.2	
Jagajaga	77.7	76.8	74.0	
Kalgoorlie	63.9	63.8	62.4	
Kennedy	63.2	64.5	64.2	
Kingsford-Smith	93.0	92.8	92.1	
Kingston	78.3	78.6	74.6	
Kooyong	71.6	69.5	65.4	
La Trobe	79.3	77.4	72.8	
Lalor	91.3	90.6	89.2	
Leichhardt	81.4	81.0	80.7	
Lilley	86.9	84.4	80.0	
Lindsay	93.8	93.0	92.8	
Lingiari	71.2	71.5	71.2	
Longman	92.8	92.3	89.8	
Lowe	94.0	93.8	93.1	
Lyne	66.3	68.3	66.6	
Lyons	72.1	69.4	68.1	
Macarthur	91.8	90.9	91.1	
Mackellar	79.7	79.4	77.9	

Macquarie	80.5	79.8	78.7	
Makin	78.0	77.8	70.4	
Mallee	55.2	55.4	53.8	
Maranoa	55.0	54.1	53.6	
Maribyrnong	92.2	92.0	89.8	
Mayo	68.2	66.4	60.3	
McEwen	73.5	71.8	70.3	
McMillan	68.3	67.7	68.0	
McPherson	85.0	83.5	80.0	
Melbourne	89.7	88.7	86.8	
Melbourne Ports	84.3	82.6	77.3	
Menzies	80.1	80.3	78.2	
Mitchell	82.3	82.9	82.6	
Moncrieff	84.1	83.0	77.9	
Moore	80.1	77.6	74.4	
Moreton	88.9	88.9	85.1	
Murray	41.2	40.7	37.2	
New England	57.3	56.2	54.1	
Newcastle	78.9	78.8	76.0	
North Sydney	73.5	71.9	70.0	
O'Connor	50.5	48.9	50.5	
Oxley	92.8	92.3	89.7	
Page	52.7	50.4	48.7	
Parkes	63.1	61.7	63.2	
Parramatta	92.5	92.8	92.6	
Paterson	69.1	68.0	64.5	
Pearce	78.2	78.2	74.5	
Perth	88.1	87.2	84.2	
Petrie	87.1	86.7	82.7	
Port Adelaide	91.0	90.6	89.9	
Prospect	97.8	97.8	97.8	
Rankin	94.4	94.4	92.7	
Reid	98.3	98.3	98.2	
Richmond	78.1	75.3	71.1	
Riverina	46.1	44.7	45.1	
Robertson	80.9	77.1	70.7	
Ryan	75.2	73.5	67.2	
Scullin	91.1	90.6	88.5	
Shortland	78.9	72.5	62.3	
Solomon	62.4	61.3	60.4	
Stirling	86.3	85.1	83.1	
Sturt	71.3	70.4	65.7	
Swan	84.0	83.8	81.3	
Sydney	91.4	90.1	87.4	
Tangney	75.6	73.8	71.4	
Throsby	92.6	92.7	93.0	
Wakefield	53.0	51.8	47.3	
Wannon	55.5	55.4	55.0	
Warringah	77.6	77.3	75.7	
Watson	97.0	97.1	96.9	
Wentworth	83.7	81.2	77.6	
Werriwa	96.0	95.8	95.8	

Wide Bay	69.2	69.7	67.4	
Wills	91.0	90.0	88.1	
Undefined	74.5	73.9	72.6	

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-186

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – REALIGNING COPAYMENTS AND SAFETY NETS

Written Question on Notice

Senator McLucas asked:

Was advice sought from any of the Pharmaceutical Benefits Scheme (PBS) advisory committees about the level of copayment increases to the PBS in this year's Budget and if so, what advice did they provide?

Answer:

It is usual practice to keep proposed Budget measures confidential prior to their announcement. Consistent with this, advice was not sought from any of the PBS advisory committees about the level of patient copayment increases prior to the Budget.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-187

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – BUDGET SAVINGS

Written Question on Notice

Senator McLucas asked:

(a) What types of modelling does the Department use to estimate the Budget savings to the PBS outlined in the Portfolio Budget Statements?
(b) What assumptions underpin this modelling?

Answer:

(a-b) The Department has a model for projecting PBS expenditure for the Budget and forward estimates years, which it used as a basis for estimating the impact of the various PBS savings measures announced in the Budget.

The model is based on monthly Health Insurance Commission (HIC) data from 1991-92 onwards. The historical HIC expenditure and prescription volume data is combined with Australian Bureau of Statistics population data, and Department of Family and Community Services data on concession card holders, with the resulting data series then being used to project future PBS expenditure and prescription volumes. The projections are adjusted for any known future impacts not captured by the historical data (for example, announced policy changes which have not yet been implemented).

The savings estimates for the PBS Budget measures were derived using the projections contained in the PBS model and behavioural assumptions which varied for each of the measures. For example, the savings estimate for the measure to increase PBS copayments and safety nets used the projections of PBS prescription volumes and costs in the model for concessional and general patients, combined with estimates made of the reduction in demand for pharmaceutical benefit prescriptions as a result of higher copayments, and estimates made of the reduction in subsidised prescriptions flowing from more prescriptions falling under the general patient copayment threshold.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-188

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – GROWTH

Written Question on Notice

Senator McLucas asked:

(a) On the basis of the most recent data, what is the estimated growth in the PBS?
(b) Has the rate of growth slowed, if so, what has caused this slowing?

Answer:

(a) The latest estimates for PBS growth, made at the time of finalising the 2002-03 Budget, are as follows:

	2001-02	**2002-03**	**2003-04**	**2004-05**	**2005-06**
PBS expenses ($ billion)	4.775	4.760	5.139	5.559	5.984
% growth over previous year	12.2	-0.03	7.9	8.2	7.6

(b) Growth in 2001-02 will be significantly below the rate of 21.9% experienced in 2000-01. This is mainly because two new drugs listed on the PBS in 2000-01 had a substantial one off impact on growth rates in that year which did not flow through to 2001-02. These drugs are Celebrex for the treatment of arthritis and Zyban for the treatment of nicotine dependence.

(c) Projected PBS growth rates for the Budget and forward estimates years are lower than the average growth rate for the Scheme of around 14% experienced in the 1990's. In this regard the measures announced in the 2002-03 Budget to adjust patient copayments and safety nets, improve the quality use of PBS medicines, and facilitate the use of generic medicines are estimated to produce net budgetary savings of around $1.9 billion over the next 4 years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-189

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – LEVEL OF SAVINGS

Written Question on Notice

Senator McLucas asked:

(a) On page 84 of the Portfolio Budget Statement, the budgeted savings from – Realigning Patient Copayments and Safety Nets are outlined. What level of savings outlined does the Department estimate from general patient increases in the copayment?
(b) What level of savings outlined does the Department estimate from concession patient increases in the copayment?
(c) What level of savings outlined does the Department estimate from general patient increases in the safety net?
(d) What level of savings outlined does the Department estimate from concession patient increases in the safety net?
(e) What savings are estimated from an increase in the number of medicines being fully funded by the copayment?
(f) What are the estimated savings to the PBS from the reduced patient demand ie, from the reduced rate at which patients fill their scripts because of the increased copayment/safety net costs to them?

Answer:

The information on budget savings is set out in the table below. The figures are in expense, not cash, terms.

Types of savings	**Total savings 2002/03 to 2005/06**
(1) Estimated savings from the Budget measure to increase the copayment and safety net for general patients*	$516.986m
(2) Estimated savings from the budget measure to increase the copayment and safety net for concession patients**	$539.212m
(3) Estimated saving from an increase in the number of medicines falling under the copayment	$38.022m
(4) Estimated saving from reduced patient demand due to the higher copayment and safety net	$140.813m

* Estimated savings from the budget measure to increase the copayment and safety net for general patients (1) include savings from medicines falling under the copayment and saving from reduced patient demand due to the higher copayment and safety net.

** Estimated savings from the budget measure to increase the copayment and safety net for concessional patients (2) include savings from reduced patient demand due to the higher copayment and safety net.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-190

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – COST EFFECTIVE SPENDING

Written Question on Notice

Senator McLucas asked:

Can the Department provide an estimate of what cost effective spending through the PBS can save in terms of other health care expenditure?

Answer:

The Department does not have available to it an estimate of the overall reductions in expenditure in other parts of the health system resulting from expenditure under the PBS.

When submissions are made by pharmaceutical companies to list new drugs on the PBS, cost offsets of this kind can be taken into account. These include reductions in diagnostic, medical, hospital, residential age care and allied health services costs which may result from the listing of a new drug on the PBS. In general these cost offsets, where identified, have been small compared with the costs of listing the drug on the PBS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-191

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – LONG TERM ESTIMATES

Written Question on Notice

Senator McLucas asked:

(a) Has the Department made any long term estimate of the cost to the health system of patients failing to take PBS medicines because of higher copayments and safety nets?
(b) If so, what assumptions were used to make these estimates and what were the estimated costs?
(c) If this has not been done, why not?

Answer:

(a) No. It is not considered that there will be a cost to the health system from this change. The PBS safety net arrangements will continue to provide considerable protection to patients holding concession cards and others who need to use a lot of medicines. It is expected that there will be some reduction in the rate of growth in prescription volumes following the increase in copayments and safety net levels. However it is anticipated that the volume of prescriptions will continue to grow over time, along with the Scheme as a whole.

(b) See (a).

(c) See (a).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-192

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS – HEALTH CARE CARD

Written Question on Notice

Senator McLucas asked:

(a) What has been the additional cost to the PBS of extending the Health Care Card to self-funded retirees for the years 2001-02 and what is the Budget projection for 2002-03 and 2003-04?
(b) How many self-funded retirees now have health cards?
(c) What is the average cost to the PBS of a pensioner health cardholder?
(d) What is the average cost to the PBS of a self-funded retiree health cardholder?

Answer:

(a) The Health Care Card is issued to recipients of income support allowances and is not available to self-funded retirees. However, the Commonwealth Seniors Health Card (CSHC) is available to self-funded retirees of age pension age subject to an income test.

The CSHC was introduced from 1 April 1994. In the 2001-02 Budget the income limit for access to the CHSC were raised to a taxable income of $50,000 a year for singles or $80,000 a year for couples, adjusted for any dependent children.

The additional PBS expenses from this measure were estimated at:

2001-02 $m	**2002-03 $m**	**2003-04 $m**	**2004-05 $m**
22.5	24.7	27.0	29.3

(b) The Department of Family and Community Services advises that it had 275,268 CSHC cards on issue as at 30 April 2002

(c-d) The current average cost of providing pharmaceutical benefits across all categories of concession card holders is estimated at $473 per year. The Department is not able to break this amount up between particular categories of concession card holders, such as those holding a Pensioner Concession Card or a CSHC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-193

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS - WHOLESALERS REVIEW

Written Question on Notice

Senator McLucas asked:

Please provide a copy of the report currently being written as part of the wholesalers review process when it is finalised.

Answer:

The report on the review of the arrangements for the wholesaling of pharmaceuticals under the Pharmaceutical Benefits Scheme is yet to be finalised. The report is expected to be finalised around the end of July, at which time it will be presented to the Minister for Health and Ageing. A decision will then be made in regard to the public release of the report.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-194

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

(a) Is the development of the better medicine management system on schedule? If not why not?

(b) To what extent has the transfer of the GP Computing Group from the AMA to the RACGP impacted on the timely rollout of this system?

Answer:

(a) The original schedule for the Better Medication Management System (BMMS) was revised to allow an extensive consultation process and additional time for desktop software development. Field Tests are expected to be conducted in 2003 with proposed full implementation from 2004.

(b) Timing of the BMMS has not been affected by the transfer of the GP Computing Group.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-195

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

(a) How much money has been spent to date on this system?
(b) What is budgeted for 2002-03 financial year?

Answer:

(a) To date $32.382 million has been spent on BMMS and related projects (including the IME initiative to include Medicare numbers on claims for medicines subsidised under the Pharmaceutical Benefits Scheme). Of this $24.629 million has been paid to HIC for systems development.

(b) The BMMS budget for 2002-03 is $22.166 million, being $9.293 million of administered funds and $12.873 million of departmental funds.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-196

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

(a) Are there any pilot projects underway, please provide details of any?

(b) How many doctors and pharmacies are involved in each pilot?

Answer:

(a) There are no pilot projects underway.

(b) Not applicable.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-197

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

(a) How will patients be uniquely identified and how will their privacy be protected?

(b) The department sought any advice from the privacy commissioner on this program and if so what advice has been provided?

Answer:

(a) The use of the Medicare number as the identifier is a part of the business model that was developed by the BMMS Development Group, a Ministerial advisory group of stakeholders. The appropriateness of the use of the Medicare number as a patient identifier will be evaluated through the BMMS Field Test.

The draft BMMS Bill provides protection of privacy in addition to mechanisms provided under the privacy legislation. It proposes that breach of clauses dealing with the use of the Medicare number for the purposes of BMMS will, in addition to protection under general privacy laws, invoke specific administrative and/or criminal sanctions.

(b) The Office of the Federal Privacy Commissioner has been involved in the development of the BMMS from its beginnings. Their involvement has been through their membership in the BMMS Privacy Working Group from its inception in July 2000. There has also been a series of separate meetings between the Department and the Privacy Commissioner's office about privacy issues in the BMMS and their comments are being taken into account in the Department's further work on the draft legislation and design of the Field Test.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-198

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Hansard Page: Written Question on Notice

Senator McLucas asked:

(a) How much is or has been paid as incentives for doctors to participate?
(b) On what basis are these incentives paid or will be paid?

Answer:

(a) No incentives have been paid to doctors to date for BMMS participation.

(b) The basis for incentives for doctors participating in BMMS is currently being determined in consultation with key stakeholders, but details have not been finalised.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-199

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

Please detail all consultancy cost on this program including past costs and budgeted costs?

Answer:

Consultancy and funding agreement costs to date relating to the Better Medication Management System are detailed below.

Consultants/Funding Agreements 2000/01/02			
Company	***Description***	**Total Amount $**	**Status**
Taylor Nelson Sofres	Preliminary Name Selection Research (Better Medication Management System)	$20,240	Complete
Wendy Bloom	Market testing / attitudinal research for BMMS	$89,129	Complete
ICS Global	The Implementation of a Standard EAN Coding System for Pharmaceutical Products (originally budgeted $405,625)	$334,314.88	Complete
Taylor Nelson Sofres	Name Short-listing Selection Research	$39,250	Complete
Gartner	A Review of the Technical Options for System Architecture for the Better Medication Management System	$70,000	Complete
Pharmaceutical Society of Australia	Consultation Workshops	$20,000	Complete
Consumer Health Forum	Consumer & E-health Project	$130,000	Complete
Albert Research	BMMS Final Name Selection Research	$38,940	Complete
Consumer Health Forum	Obtain and provide consumer input to BMMS development	$55,616	Ongoing $35,616 Paid
KPMG Consulting Australia Pty Ltd	To report on the compliance of the BMMS with Standards of interoperability to enable future integration with the proposed HealthConnect System	$75,793	Ongoing Paid $0
Katharina Darbyshir	Research & Review on International Experiences of Projects that are Comparable with BMMS	$5,000	Complete
Walter & Turnbull Pty Ltd	Consider the Governance & Quality Assurance Role of the MCCA with Particular regard to the Introduction and Use of Standardised Medicines Codes and Associated Liability Issues	$180,397	Ongoing Paid $0
Pricewaterhouse Coopers	BMMS Baseline Data Collection Consultancy	$55,000	Ongoing Paid $0

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-200

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

(c) Who is providing the IT and software expertise for this system to the HIC?
(d) Who will provide IT assistance to doctors participating in the program?
(e) What funding for IT support offices to the Division of General Practice has been made available over each of the funding years for this program?

Answer:

(a) HIC has outsourced its IT infrastructure services to IBM/GSA, and BMMS will operate on the IT infrastructure provided by this organisation.

The software is being developed by the BMMS Project Team within HIC. This team has previously included contractors from Accenture who provided expert advice and guidance through their role as e-business integrators.

Consultancies have also been undertaken to provide advice in specific areas:

- Standards Australia and HL7 individual experts – for HL7 Standards;
- Gartner – for review and endorsement of BMMS technical design.

Assistance with testing of Software Vendors' interfaces with the BMMS is being provided by Aspect Computing under contract.

(b) The IT assistance to doctors participating in the BMMS will be provided by their Prescription Writing Software vendor, who will work closely with HIC and the local Division of General Practice where appropriate, to optimise the operation of the system.

(c) Distribution of funding for training and support activities for the BMMS has not yet been determined. No funding has been specifically provided to Divisions of General Practice for IT support officers for the BMMS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-201

OUTCOME 2: ACCESS TO MEDICARE

Topic: BETTER MEDICATION MANAGEMENT SYSTEM

Written Question on Notice

Senator McLucas asked:

(a) What savings to the PBS does the Department estimate will be generated by this program?

(b) What is the estimated cost effectiveness of this program?

Answers:

(a) Projected PBS savings arising from BMMS are as follow:

	03-04	**04-05**	**05-06**	**Total**
PBS Savings ($m)	-11.689	-62.052	-107.259	**-181.000**

(b) The objective of BMMS is to reduce adverse drugs events associated with medication use and thereby improve peoples' health. It is difficult to quantify these diffuse benefits, but recent research indicates that there are an estimated 80,000 hospitalisations result from adverse drug events each year, costing about $350 million, of which between 32% and 69% are preventable. [Roughead E, Gilbert A, Primrose J and Samson l, *Drug-Related Hospital Admissions: A review of Australian studies published 1988-1996*, Medical Journal of Australia, vol. 168, 20 April 1998]

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-202

OUTCOME 2: ACCESS TO MEDICARE

Topic: COUNSELLING FOR INAPPROPRIATE PRESCRIBING

Written Question on Notice

Senator McLucas asked:

Please provide following figures for GPs and by individual specialty.

(a) How many doctors were counselled for inappropriate prescribing during the 2000-01 and 2001-02 financial years?
(b) How are the doctors identified?
(c) Which drugs are most commonly involved? Please provide list of top 10 drugs at risk of inappropriate prescribing.

Answer:

(a) Of the 616 doctors that were counselled in 2000-01, 168 doctors were counselled in respect of their prescribing. It is not possible to separate this data into individual specialties.

Of the 594 doctors counselled in the financial year to date (July 2001-May 2002), 149 doctors were counselled in respect of their prescribing. It is not possible to separate this data into individual specialties.

(b) The doctors are identified by various methods of targeting tools and techniques including artificial intelligence, data mining, neural networks, data extraction and data interpretation.

(c) The HIC presently only look at the following four groups of drugs:

- Benzodiazepines
- Narcotic Analgesics
- Codeine Compounds
- Temazepam

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-203

OUTCOME 2: ACCESS TO MEDICARE

Topic: FACILITATING THE USE OF GENERIC MEDICINES

Written Question on Notice

Senator McLucas asked:

Page 83 of the Portfolio Budget Statements outlines savings to the Budget from the use of generic medicines.

(a) For which medications is the Government currently negotiating agreements with manufacturers?
(b) Where are these negotiations up to? Have any agreements been signed? If not, when are any likely to be signed?
(c) Are price volume agreements part of these negotiations?
(d) How will the Department regulate prescribing software?

Answer:

(a-b) All generic medications which are listed on the PBS are being included in these negotiations. It is intended that the negotiations be concluded in time to allow the consequent price changes to take effect from 1 November 2002.

(c) No.

(d) The changes required to prescribing software will be achieved through an amendment to Regulation 19 of the National Health (Pharmaceutical Benefits) Regulations 1960. Regulation 19 sets out the requirements for the writing of prescriptions.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-204

OUTCOME 2: ACCESS TO MEDICARE

Topic: PHARMACY FRAUD

Written Question on Notice

Senator McLucas asked:

(a) Please list the types of fraud this measure in the portfolio budget statement page 85 is targeting?
(b) What are the expected savings from fraud by pharmacists?
(c) What are the expected savings for fraud on pharmacists?
(d) How are suspected pharmacies identified?
(e) How many pharmacists have been investigated for fraud in the past 5 years?
(f) How many pharmacists have been prosecuted for fraud in the past 5 years?
(g) What are the costs of this program?

Answer:

(a) The types of fraud targeted in the budget proposal are those relating to pharmacies. These frauds include pharmacists defrauding the PBS claims process. Other frauds relate to members of the public presenting false or altered prescriptions, identity fraud and diversion of PBS drugs overseas.

(b) The expected savings from the budget measure cannot be differentiated between fraud committed by, or fraud committed on, pharmacists. The savings from the budget measure are estimated to be $201.3 million over four years.

(c) The expected savings from the budget measure cannot be differentiated between fraud committed by, or fraud committed on, pharmacists. The savings from the budget measure are estimated to be $201.3 million over four years.

(d) Pharmacies suspected of committing fraud could be identified to the HIC through a number of means. The HIC currently uses sophisticated rules-based neural network technology to identify high-risk pharmacies and continually looks to further develop these advanced data analysis techniques. Some of those cases may be referred for consideration of investigation, audit or other action. Pharmacies that are subjected to routine random audits may also result in a referral for investigation.

The HIC also receives information from other agencies, practitioners and members of the public about suspected pharmacy fraud. Cases identified from this information are treated in a similar manner to those arising from the HIC's data analysis processes, mentioned above.

(e) Over the past five years there have been twenty-five cases where pharmacists have been investigated and the cases closed without prosecution action being taken.

(f) There have been eleven pharmacist prosecutions leading to conviction in the past five years.

(g) The expected cost of this program is $11.175 million over four years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question:E02-205

OUTCOME 2: ACCESS TO MEDICARE

Topic: VISUDYNE

Written Question on Notice

Senator McLucas asked:

(a) Did the Medical Services Advisory Committee consider the listing of Visudyne on the MBS? If so, what was the outcome of that consideration? If not, why was MSAC not involved?
(b) Is the budget decision re Visudyne consistent with the recommendation?

Answer:

(a) Yes. The Medical Services Advisory Committee (MSAC) received an application for funding of photodynamic therapy with verteporfin ('Visudyne™ therapy') for macular degeneration on 6 September 2000. MSAC reviewed the evidence in the scientific literature on the procedure's safety, effectiveness and cost-effectiveness at their 24 August 2001 meeting and concluded that the procedure should be funded for patients with the particular form of macular degeneration that is likely to benefit from the treatment.

More specifically the MSAC recommendation to the former Minister for Health and Aged Care, Dr Michael Wooldridge was as follows:

"MSAC has reviewed the evidence relating to photodynamic therapy for macular degeneration (MD) in terms of clinical need, safety, effectiveness and cost-effectiveness. MSAC recommends that public funding for this therapy should only be supported for patients with predominantly classic (>50% classic) subfoveal choroidal neovascularisation secondary to MD, a small minority of MD cases. For this sub-group of MD patients, there is some evidence that the therapy may retard the rate of visual loss in the short term.

"As there is insufficient evidence of the effectiveness or cost-effectiveness of photodynamic therapy to support funding for this treatment outside the indications outlined above, the Committee also recommends that public funding should only be supported where arrangements are in place to ensure, as far as possible, that the indications in the previous paragraph are met."

(c) Yes. The budget decision on Visudyne™ therapy is consistent with the recommendation made by the MSAC. Funding for the Visudyne™ drug and the related medical procedure has been provided through a health program grant since 1 June 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-206

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

The Report of the Review of Professional Indemnity Arrangements for Health Care Professionals (the Tito Report) was released in 1996. This report recognised that there were severe problems in the system that provides medical indemnity insurance to Australian doctors and made a number of recommendations to address this.

(a) What actions did the Department take to address any of these recommendations?

(b) If none were taken why not?

(c) Would implementation of the recommendations of this report have prevented this current crisis?

(d) If not, why not?

Answer:

(a) The Government made a decision about what recommendations it could most usefully address. It chose to address systematic safety and quality issues in health service provision and the reduction of adverse events for patients.

(b) The Commonwealth did address issues raised in the report – see (a) above. Parties including the States and Territories and the medical profession also have responsibilities in relation to medical indemnity and it was open to them to address issues in the Tito report.

(c) This is a matter of speculation.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-207

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY - THE GOVERNMENT RESPONSE TO THE SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE ON CHILD BIRTH PROCEDURES "ROCKING THE CRADLE" (AUGUST 2000).

Written Question on Notice

Senator McLucas asked:

Recommendation 20 states:
"The Committee recommends that the Commonwealth Government continues to fund midwives to assist at home births for women at low risk …"

(a) Given that many midwives are now unable to practice because of the unavailability of affordable indemnity cover, what action does the Government propose to take to address this issue?
(b) Why were midwives not included in the interim cover provided to doctors?

Answer:

(a) Indemnity cover for midwives is one of the broader issues of professional indemnity that are currently being addressed by Senator Coonan, Minister for Revenue and Assistant Treasurer, in her work on public liability.

(b) The government has not provided interim cover to doctors as such. The government has provided a guarantee to the provisional liquidator of United Medical Protection (UMP) to enable him to meet claims and provide cover over the period of the guarantee, to all UMP members. Generally, midwives purchase their professional indemnity insurance from general insurers, not medical defence organisations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-208

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY - THE GOVERNMENT RESPONSE TO THE SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE ON CHILD BIRTH PROCEDURES "ROCKING THE CRADLE" (AUGUST 2000).

Written Question on Notice

Senator McLucas asked:

Recommendation 34 states:
"The Committee recommends that the AIHW establish national comprehensive data on medical defence organisations to cover negligence cases and include such data as premium payments, number of cases, number of claims, number of out of court settlements, size of payments and size of fund reserves."

The government response was that this was not a priority and that there was no evidence to support funds being allocated to this.

Was this a correct response, given what has resulted and what will need to be done to address the current problems?

Answer:

It is not evident that the establishment of a national database would have avoided the current financial problems experienced by United Medical Protection.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-209

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY - THE GOVERNMENT RESPONSE TO THE SENATE COMMUNITY AFFAIRS REFERENCE COMMITTEE ON CHILD BIRTH PROCEDURES "ROCKING THE CRADLE" (AUGUST 2000).

Written Question on Notice

Senator McLucas asked:

Recommendation 35 states:
"The Committee recommends that the Commonwealth Government establish an independent inquiry into medical indemnity and litigation, including the impact of litigation and indemnity on the provision and practice of obstetric services, alternate approaches to the funding of medical litigation and alternative approaches to the funding of compensation for disability."

The government response was that "it does not believe that an independent inquiry into medical indemnity is appropriate at this point."

(a) Given what has eventuated, was this the wrong response?
(b) Who provided this response to the report? Who was consulted in the provision of this response?

Answer:

(a) This is a matter of opinion. However, it is not evident that an inquiry would have avoided the current financial problems experienced by United Medical Protection.

(b) This was a whole of government response.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-210

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

The Family Planning Association in NSW has been forced to close its doors and its clinical, health promotional and education services - and even its website, because it cannot find health insurance.

The clinical services of this organisation are funded by the Commonwealth, which requires medical indemnity as part of the contract for the provision of these services.

Why will the Commonwealth not offer interim cover to FPA?

Answer:

The Commonwealth does not provide medical indemnity cover to any health service providers.

We are advised that Family Planning Australia (FPA) has found alternative cover.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-211

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

Why will the Commonwealth not offer indemnity cover for Aboriginal Medical Services?

Answer:

The Commonwealth does not provide medical indemnity cover to any health service providers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-212

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

Already we are reading that doctors are increasing their charges to cover their medical indemnity levy.

What action will the Government take to ensure that doctors do not pass on their levy costs to patients?

Answer:

The details of the Commonwealth's scheme to fund the incurred but not reported liabilities of medical defence organisations such as United Medical Protection are still being worked out. While this will involve a levy to doctors, the levy has yet to be introduced. Consequently, even if such reports of current increases in patient fees are true, these increases cannot be attributed to a levy.

The Prime Minister's statement of 31 May stated that "details of the levy arrangements will be developed in consultation with affected medical practitioners … with the aim that: levies will be affordable, with amounts funded over a period of at least five years". The government does not expect that doctors would need to pass on levy costs in the future.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-213

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY

Written Question on Notice

Senator McLucas asked:

When the GST was implemented, the Government had the ACCC looking at undue price rises to help protect the public.

(a) Will the Government involve the ACCC in this case?
(b) If not, why not?

Answer:

(a) The Government has no plans to involve the Australian Competition and Consumer Commission (ACCC) at this stage. However, the ACCC may choose to involve itself on its own initiative.

(b) The Commonwealth expects the levy to be an affordable amount which should not lead to increases in the price of medical services.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-049

OUTCOME 2: ACCESS TO MEDICARE

Topic: MEDICAL INDEMNITY

Hansard Page: CA 333

Senator Allison asked:

I am advised that Queensland, South Australia and Western Australia are those where the problem is most acute. I am also advised that the department was advised of this some time ago. I think it was said yesterday that there was no knowledge of it, and I ask on notice if you could have a look at where that advice went to if it did not reach the appropriate people?

Answer:

The department is not aware of a specific piece of advice referring to problems relating to students in clinical placements in Queensland, South Australia and Western Australia.

On 6 June Senator Patterson stated that she had replied to a letter from university vice-chancellors (Hansard, CA 333). Copies of this correspondence are attached.

SENATOR THE HON KAY PATTERSON
Minister for Health and Ageing

Professor Gavin Brown
Vice-Chancellor and Principal
The University of Sydney
SYDNEY NSW 2000

Dear Professor Brown,

Thank you for your letter of 6 May 2002 co-signed with Professors Holmes and Ingleson, concerning medical indemnity cover for university medical training.

I note your concerns regarding the difficulties university medical academics and students in New South Wales are having obtaining indemnity insurance. While I understand these concerns, I believe that there is some confusion over the responsibility for academics' indemnity insurance, particularly where their clinical work is undertaken in public hospitals.

The Commonwealth may have a role in funding university training, but the statement made by Mr Robert McGregor, cited in your letter, to the effect that the Commonwealth has primary responsibility in this area, is not correct. Regulation of universities and their activities is, as you know, a State responsibility. I also note that public hospitals benefit from the provision of training services, given that these enhance the skills and experience on hand for patient care, and that public hospitals are also a State responsibility.

Therefore, it is the view of the Commonwealth, that any further funding required for medical indemnity insurance for academics should properly come from the State government. It seems to me that one possible solution would be for the State government to cover the risks of training and teaching activities conducted in public hospitals under similar conditions to those available to visiting medical officers (VMOs). I have already written on this subject to the New South Wales Minister for Health.

You will be aware that the Commonwealth has been working very actively towards a resolution of the current uncertainties surrounding medical indemnity insurance. In particular we have provided a guarantee to the provisional liquidator of United Medical Protection which will enable him to renew members' insurance policies on a 'claims made' basis until 31 December 2002. In addition, officials are working on the details of a scheme to assist medical defence organisations to manage their unfunded 'incurred but not reported' liabilities.

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Combined with tort law reform, improved prudential requirements and initiatives to reduce the long-term costs of 'catastrophe' cases, I believe that there is reason to be optimistic about the long-term availability of affordable medical indemnity insurance.

Thank you for bringing this issue to my attention.

Yours sincerely,

Senator Kay Patterson

- 7 JUN 2002

SENATOR THE HON KAY PATTERSON
Minister for Health and Ageing

Professor Roger Holmes
Vice-Chancellor and President
The University of Newcastle
NEWCASTLE NSW 2308

Dear Professor Holmes,

Thank you for your letter of 6 May 2002 co-signed with Professors Brown and Ingleson, concerning medical indemnity cover for university medical training.

I note your concerns regarding the difficulties university medical academics and students in New South Wales are having obtaining indemnity insurance. While I understand these concerns, I believe that there is some confusion over the responsibility for academics' indemnity insurance, particularly where their clinical work is undertaken in public hospitals.

The Commonwealth may have a role in funding university training, but the statement made by Mr Robert McGregor, cited in your letter, to the effect that the Commonwealth has primary responsibility in this area, is not correct. Regulation of universities and their activities is, as you know, a State responsibility. I also note that public hospitals benefit from the provision of training services, given that these enhance the skills and experience on hand for patient care, and that public hospitals are also a State responsibility.

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Senator Kay Patterson

- 7 JUN 2002

SENATOR THE HON KAY PATTERSON
Minister for Health and Ageing

Professor John E Ingleson
Acting Vice Chancellor
The University of New South Wales
RANDWICK NSW 2031

Dear Professor Ingleson,

Thank you for your letter of 6 May 2002 co-signed with Professors Brown and Holmes, concerning medical indemnity cover for university medical training.

I note your concerns regarding the difficulties university medical academics and students in New South Wales are having obtaining indemnity insurance. While I understand these concerns, I believe that there is some confusion over the responsibility for academics' indemnity insurance, particularly where their clinical work is undertaken in public hospitals.

The Commonwealth may have a role in funding university training, but the statement made by Mr Robert McGregor, cited in your letter, to the effect that the Commonwealth has primary responsibility in this area, is not correct. Regulation of universities and their activities is, as you know, a State responsibility. I also note that public hospitals benefit from the provision of training services, given that these enhance the skills and experience on hand for patient care, and that public hospitals are also a State responsibility.

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Thank you for bringing this issue to my attention.

Yours sincerely,

Senator Kay Patterson

- 7 JUN 2002

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-042

OUTCOME 2: ACCESS TO MEDICARE

Topic: PRICE OF COX II DRUGS

Hansard Page: CA291

Senator Evans asked:

Did the price adjustment on Celebrex occur before Vioxx came on the market, or did they both get their price adjusted after they had both been on the market for a while?

Answer:

Celebrex was listed on the Pharmaceutical Benefits Scheme (PBS) from 1 August 2000 and Vioxx was listed on the Scheme from 1 February 2001. There was a price adjustment made to Celebrex from 1 May 2001 which mainly reflected the fact that the maximum quantity of capsules allowed per prescription was reduced from 60 to 30 for the 200mg strength of this medicine. This did not affect the pricing of Vioxx.

Celebrex and Vioxx are priced similarly on a daily treatment cost basis.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-044

OUTCOME 2: ACCESS TO MEDICARE

Topic: NATIONAL PRESCRIBING SERVICE FUNDING

Hansard Page: CA 298-9

Senator Crowley asked:

(a) Is it possible to provide for the committee the amount of money the government is actually spending in this particular project?

(b) Professor Smallwood referred to a few other practices outside of them, as in research material. If you could provide for us a handle on the dollars being expended there that would be helpful too… Including any evidence of the cost when an operating theatre in a hospital has to be closed or when a hospital is discovered to have bug X that puts in jeopardy everybody who is admitted to that hospital.

Answer:

(a) The National Prescribing Service (NPS) has provided the Department with the following information. The NPS budget for this year's consumer antibiotic campaign is $500,000. The antibiotic program for prescribers is being funded as part of NPS's ongoing quality prescribing strategies.

(b) To address the issue of antibiotic resistance the Commonwealth Government is working towards a national antibiotic resistance management program. This work forms part of the implementation of the *Commonwealth Government Response to the Report of the Joint Expert Technical Advisory Committee on Antibiotic Resistance (JETACAR)* (the Government Response, August 2000). To date, the Population Health Division of the Department has spent approximately $250,000 in implementing the Government Response. Activities funded include the National Summit on Antibiotic Resistance; a workshop, State consultation meetings, and external contractor towards development of an improved surveillance system; and a contribution to support the operation of the National Health and Medical Research Council (NHMRC) Expert Advisory Group on Antimicrobial Resistance (EAGAR). Other areas of the Department of Health and Ageing, and other Departments, are providing resources for activities relating to recommendations in the Government Response that they have specific carriage for.

The Population Health Division does not collect data on hospital infections. However, an outbreak of vancomycin-resistant enterococci (VRE) occurred at the Royal Perth Hospital in late 2001. During the outbreak, no deaths were attributed to VRE, but 172 patients were found to be colonised, four with infections. Specimens from 24,000 patients and 36,000 environmental samples were tested for VRE by the end of January 2002. The media reported the cost of controlling and containing the outbreak would reach $3 million with additional cleaning procedures implemented in the hospital costing up to $80,000 per week and requiring employment of more than 100 extra cleaning staff. The Department of Health and Ageing cannot vouch for the accuracy of this data.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-223

OUTCOME 2: ACCESS TO MEDICARE

Topic: THE NATURE OF INFORMATION PASSED ON TO THE NATIONAL PRESCRIBING SERVICE.

Hansard Page: CA292

Senator Evans asked:

"That would be more general. It would not include locational patterns?"

Answer:

The National Prescribing Service (NPS) is a non-profit, independent organisation, established by the Commonwealth Government in 1998, whose primary role is to support quality prescribing practices through education programs. The NPS achieves this aim through a number of methods, including the provision of Feedback information.

The Feedback information reports that are sent to practitioners by the NPS are sourced from the Health Insurance Commission (HIC). The reports sent to each individual practitioner contains data relating to their own prescribing patterns, also included in the reports are aggregated geographical data (non-identifiable) which is used by practitioners for peer group comparison purposes.

To ensure a quality product is sent to practitioners, there are a number of testing and checking processes that are undertaken by the HIC and the NPS. HIC is responsible for and undertakes quality assurance on the data displayed within the reports, while the NPS is responsible for quality assurance of the overall Feedback product. Hence a small sample is supplied to the NPS, for validation purposes.

Under provisions contained in the contract between HIC and NPS, the NPS is required to identify to the HIC, staff members who have contact with this information. These staff members are then required to sign a confidentiality deed.

In addition, there are three parts of the contract devoted to security and privacy of personal information (much of it covered under legislation), including guidelines and ramifications (liability of prosecution) if a breach is committed. Under the contractual arrangements, any NPS staff member who has (or could potentially have), contact with confidential HIC information are briefed or otherwise made aware of the restrictions imposed of the use and disclosure of personal information. They are also made aware of NPS obligations in relation to confidential HIC information.

Under contractual obligations, the NPS cannot transfer confidential HIC data to any third party, make a copy of, or store the data for its own purposes. All confidential HIC information must be returned to the HIC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-043

OUTCOME 2: ACCESS TO MEDICARE

Topic: FULL COSTINGS OF THE BREAKDOWN OF MEASURES

Hansard Page: CA 296

Senator Evans asked:

Could you take on notice the full costings of the breakdown of the measures?

Answer:

Savings Measure excluding DVA component	**$ Million**			
Sustaining the PBS	**02/03**	**03/04**	**04/05**	**05/06**
Evidence based medicine measures • changes to the PBS listing process	- 9.1	- 8.9	- 9.8	- 10.7
• enhancement of PBS restrictions	-16.0	-31.9	- 44.6	- 48.4
• enhanced compliance in electronic authority approvals	- 2.6	-28.7	- 36.2	- 38.6
• GP electronic support	- 5.5	- 9.4	- 10.2	- 14.3
• Public Key Infrastructure	5.3	5.3	6.6	8.5
• Community Awareness	13.3	12.1	12.1	12.1

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-045

OUTCOME 2: ACCESS TO MEDICARE

Topic: INTERNATIONAL EXPERIENCE OF INCREASING INFORMATION

Hansard Page: CA 299

Senator McLucas asked:

(a) Have we looked at international experience in terms of this whole question of essentially asking the industry – and I got your letter on this – to tell doctors how to do it properly? Is there any international experience on that that you are aware of?
(b) If you could give me the references on notice it would be good to have a look at that. They are saying between two and ten per cent?

Answer:

(a)&(b)

There is a considerable body of Australian and international research into the effectiveness of education at an individual or small group level to change prescriber behaviour (see list of references below). The various studies measure the effectiveness of the interventions being trialed in different ways. These include:

- a reduction in the proportion of inappropriate prescriptions
- a reduction in the prescribing budget for the facility
- an improvement in health outcomes for patients
- reduction in length of stay for patients in acute care settings
- increased numbers of patients treated in accordance with clinical guidelines

Particular studies which quantify the benefits of improved prescribing practices are as follows:

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-046

OUTCOME 2: ACCESS TO MEDICARE

Topic: PBS SAVINGS

Hansard Page: CA302-4

Senator Evans asked:

(a) What does the Department think a change in cost to the consumer has on pharmaceutical consumption behaviour?
(b) What do we know about those that stay on the PBS, in terms of demand?
(c) So you will be able to give me an explanation of the assumptions and where those savings then, are generated?

Answer:

(a-b) An increase in the cost to the consumer of pharmaceuticals will reduce the rate of growth of pharmaceutical consumption. The reduction in demand will moderate over time.

(c) It has been assumed that, following the increase in copayments, demand for pharmaceutical benefit prescriptions will fall by 2.8 per cent for concessional patients and by 1.4 per cent for general patients. It has also been assumed that the demand response moderates over time, so that there is a full effect in the first year; a half effect in the second year; a quarter effect in the third year; and no impact by year four.

It has been estimated that, over the four year period 2002-03 to 2005-06, around 14 per cent of the $1.1 billion in savings resulting from the increase in copayments and safety nets will arise from this demand response

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-222

OUTCOME 2: ACCESS TO MEDICARE

Topic: PROCEDURES IN PLACE WHEN PHARMACISTS CALL HIC HOTLINE FOR THE PURPOSE OF CHECKING PATIENT'S ELIGIBILITY WHEN PATIENT PRESENTS WITH NO MEDICARE CARD

Hansard Page: CA310

Senator Evans asked:

"That really begs the question: how do you determine consent of the customer?"

Answer:

As a result of the introduction of the *National Health Amendment (Improved Monitoring of Entitlements to Pharmaceutical Benefits) Act 2000*, HIC established the IME Medicare Number Hotline. The Hotline allows approved pharmacists or their staff to obtain their customer's Medicare numbers or Department of Veterans' Affairs (DVA) file numbers and card expiry dates for the purpose of submitting a claim to HIC for payment.

The pharmacist, in their professional capacity, obtains the consent from the customer. The pharmacist is then required to satisfy HIC that this consent has been obtained.

To allow HIC to release Medicare numbers under the privacy provisions of the *Health Insurance Act 1973* and the *Privacy Act 1988*, the pharmacist must answer a series of questions. These are divided into three categories:

- Security (ensuring that it is an approved pharmacist or their staff member)
- Consent (ensuring that the customer has been fully advised as to why their number is being obtained, what it will be used for and that they have provided their verbal consent to the pharmacist to obtain and store that number)
- Patient details (ensuring that the pharmacist has at least two identifying sets of data for the customer e.g. name and address, or name and date of birth)

The questions are asked in the order as detailed below. If the pharmacist cannot satisfy HIC's operator that they have obtained all the necessary information from the patient, or if the details they provide do not correspond with the details held by Medicare, the call is terminated.

Security Check

1. What is your name (callers name)?
2. What is your pharmacy approval number?
3. What is the name of the pharmacy (or surgery for dispensing doctors)?

Obtaining Consent

4. Have you informed the customer of the options available when they do not provide a Medicare card?
5. Have you advised the customer why their Medicare details (number, name and/or expiry date) are needed and how they will be used?
6. Have you obtained the consent of the customer to obtain their Medicare details (number, name and/or expiry date) from HIC?
7. Have you obtained the consent of the customer to store their Medicare details (number, name and/or expiry date)?

Patient Details

8. What is the customer's name and address?
9. What is the customer's date of birth (for use when the name and address provided does not uniquely identify the patient)?

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-252OUTCOME 2: ACCESS TO MEDICARE

Topic: DRUGS AWAITING APPROVAL FOR PBS LISTING

Hansard Page: CA317 & CA318

Senator McLucas asked:

(a) Can you tell me how many drugs have been approved by the PBAC and the PBPA and are currently awaiting approval for PBS listing?
(b) When you give me the list of drugs awaiting approval between the PBAC and the PBS, could you also tell me how many drugs are waiting in the system, between completed negotiations and ministerial approval?

Answer:

(a) As at 18 September 2002, there are three drugs in this position. The three drugs are Singulair (montelukast), a drug used in the treatment of asthma; Avandia (rosiglitazone), used for the treatment of diabetes; and Spiriva (tiotropium), used for the treatment of Chronic Obstructive Pulmonary disease.

(b) As at 18 September 2002, there are no drugs in this position.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-221

OUTCOME 2: ACCESS TO MEDICARE

Topic: WHEN WAS THE HIC NOTIFIED BY NATA OF THEIR DECISION TO CANCEL MEDTEST'S NATA ACCREDITATION?

Hansard Page: CA324

Senator Evans asked:

"As a result of checks. When were you advised about that?"

Answer:

NATA first issued an adverse assessment report of Medtest's laboratory at Fairfield Heights, NSW on 9 October 2000. The NATA report did not suggest there was a public health risk with Medtest.

On 20 October 2000, HIC asked Medtest to show cause why its laboratory approval should not be revoked.

Medtest's response indicated that the deficiencies would be rectified. After considering Medtest's response, HIC did not revoke Medtest's laboratory approval but did arrange for NATA to reassess the laboratory on 22 March 2001.

On 1 May 2001 HIC received the NATA assessment report for an inspection of Medtest's laboratory held on 22 March 2001.

Following consideration of the NATA report, on 31 May 2001 HIC gave Medtest a new show cause notice asking Medtest to explain why its application for a new laboratory approval should not be refused.

On 13 June 2001 Medtest notified HIC that it was commencing an appeal process under NATA's by-laws. Medtest submitted that HIC should not make a decision to remove its laboratory approval until the appeal process concluded.

HIC places a great deal of weight on NATA reports. Given the NATA appeal processes could change the recommendations in a NATA report, HIC decided to wait until the NATA appeal processes were complete before making a decision as to whether or not to withdraw approval of Medtest's laboratory.

On 20 August 2001 the Board of NATA resolved to cancel Medtest's NATA accreditation. Medtest commenced a further appeal under NATA's by-laws in relation to this decision.

HIC considered that it was appropriate to wait until Medtest had its appeal considered before taking a decision in relation to Medtest's laboratory approval.

HIC wrote to NATA on 7 September 2001 and asked NATA to consider any appeal urgently.

Medtest has had its laboratory approval, to perform services eligible for Medicare rebate: revoked (14 March 2002); not approved (30 April 2002); and, not extended (30 April 2002) – by a delegate of the Minister at the HIC.

In each instance, Medtest appealed to the Administrative Appeals Tribunal (AAT) immediately following the delegate's decision.

Consistently, the AAT has made interim orders to the effect that Medtest's lab be approved until the end of a final hearing of the matter in the AAT.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-048

OUTCOME 2: ACCESS TO MEDICARE

Topic: NUCHAL TRANSLUCENCY MEASUREMENT

Hansard Page: CA 326-7

Senator Herron asked:

How many people in Australia are accredited for the measurement of nuchal translucency?

Answer:

The measurement of nuchal translucency is not funded under Medicare and therefore the Department is not involved in regulating the service to ensure it is only undertaken by appropriately accredited service providers.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question:E02-247

OUTCOME 2: ACCESS TO MEDICARE

Topic: Chronic Fatigue Syndrome (CFS) guidelines

Hansard Page: CA 340-341

Senator West asked:

"Maybe you would like to look at that and make some comment back to me" (reaction and response of the Chief Medical Officer in Great Britain to the British review)

Answer:

The UK Government's response, like the RACP guidelines, recognises CFS/ME as a chronic illness. It identifies areas for action, including the need for more research on a wide range of aspects of CFS/ME, the need for improving treatment and care and acknowledges that the illness represents a substantial problem in the young.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question:E02-052

OUTCOME 2: ACCESS TO MEDICARE

Topic: POSITRON EMISSION TOMOGRAPHY (PET) SCANNERS

Hansard Page: CA 355

Senator West asked:

We had a briefing from the department and we indicated at the time that we would like that briefing to be made available on the public record. I think it was being sanitised into an appropriate form so that it could be. Could we have that information, please?

Answer:

1. Background to the Positron Emission Tomography (PET) Review

PET is a nuclear medicine technology that uses short-lived radioisotopes to allow the non-invasive diagnostic imaging of metabolic processes. It is an expensive technology, requiring sophisticated scanners, a trained workforce, and cyclotrons to produce radioisotopes. It has been in use overseas for some twenty years, mainly in a research role, and for a decade in Australia. Prior to the recent tender process, there were two publicly funded PET facilities in Australia: at the Austin and Repatriation Medical Centre (Austin) and the Royal Prince Alfred Hospital.

Following receipt of two applications seeking to expand access to PET services, the chair of the Medical Services Advisory Committee (MSAC) wrote to the Minister for Health and Aged Care, Dr Michael Wooldridge, suggesting that an examination of the broader role of PET should be undertaken. As a result, the Minister asked his department to conduct a national review of PET to determine its future role in the Australian health environment.

The department conducted the review between October 1999 and August 2000. The overall review was conducted under the guidance of a steering committee, chaired by Professor Brendon Kearney and comprising representatives of the medical profession, State and Territory governments and consumers (see list of members at Attachment A). The steering committee was responsible for consideration of the broader policy issues associated with PET, and with the preparation of the review report and recommendations for presentation to the Minister.

An integral part of the review was a technical and scientific evaluation of PET conducted by the Medical Services Advisory Committee. The MSAC Supporting Committee was chaired by Dr Richard King. The other members of that Committee are at Attachment B. MSAC reviewed the use of PET in the following clinical indications:

(a) pre-operative staging of non-small cell lung cancer (NSCLC);
(b) potentially respectable melanoma;
(c) residual / recurrent mass in patients treated for malignant glioma;
(d) suspected recurrence of colorectal cancer (CRC);
(e) medically refractory epilepsy; and
(f) assessment of myocardial viability in patients being considered for coronary revascularisation.

1.1 MSAC and its Involvement in the Review Process

MSAC was established in 1998 to implement the 1997-1998 Federal Budget initiative, aimed at strengthening the evidence base of the Medicare Benefit Schedule. MSAC advises the Minister for Health and Ageing on evidence relating to the safety, effectiveness and cost-effectiveness of new medical technologies and procedures. This advice informs government decisions with regard to which new medical services should attract funding under Medicare. MSAC's assessments are based on reviews of the scientific literature and other information sources, including clinical expertise.

1.2 MSAC's findings on PET

MSAC's findings upon conclusion of the review were largely consistent with the conclusions of existing reviews conducted by the International Network of Agencies for Health Technology assessment (INAHTA), the United States' Veteran's Affairs Technology Assessment Program (VA TAP) and the National Coordinating Centre for Health Technology Assessment (NCCHTA).

MSAC found that PET is safe but that there was insufficient evidence on its clinical or cost-effectiveness, with respect to the six indications reviewed, to warrant unrestricted Medicare funding. MSAC concluded it was potentially both clinically and cost effective and recommended that a data collection be undertaken to enable a conclusive evaluation of PET.

1.3 The Steering Committee findings on PET

The steering committee subsequently presented its report and recommendations, including the recommendations of MSAC, to the Minister, Dr Michael Wooldridge, who agreed to the implementation of the review's recommendations in August 2000. In summary, the review recommended:

- Interim funding, for a limited range of clinical indications, for 7 PET facilities nationally: 2 each in NSW and VIC; 1 each in QLD, SA and WA.
- Funding arrangements which separate out capital and recurrent costs: capital costs to be covered by grants; recurrent costs to be reimbursed through the MBS.
- A competitive tender process to determine access to funding.
- Stringent conditions of funding for individual facilities including accreditation and the provision of high-quality data.
- The evaluation by MSAC of PET's role in additional clinical indications.

2. The Tender Process

From 4 August 2001 to 7 September 2001, tenders were sought by the Commonwealth from owners or operators (or potential owners or operators) of PET facilities.
The RFT process set out to determine:

- which PET facilities would be made eligible for Medicare benefits under the 3C Determination; and
- the amount of funding (if any) that would be granted to each such successful tenderer for the establishment or upgrading of a PET facility.

2.1 Evaluation on Tenders

In response to the tender request, a total of fifteen tender proposals were received. In assessing tenders, the Tender Evaluation Panel considered the following six weighted criteria:

(a) amount of capital funding sought;
(b) patient charging;
(c) operational date;
(d) operating arrangements;
(e) patient accessibility; and
(f) services to be provided.

The relatively high weighting given to the amount of capital funding sought meant that the capital bid had a significant influence on a tenderer's final score, with a request for no capital receiving the highest possible score and progressively lower scores given for requirements for higher amounts of capital. The weighting for capital sought to balance the Commonwealth's outlays against PET's status as an unproven technology. The Request for Tender (RTF) stressed the importance of this criteria in clause 11.7(a):

> In evaluating tenders against this criterion, Health's first preference will be for tenders that seek no capital funding. Health's next preference will be for the tender that involves the least amount of capital funding from the Commonwealth.

The RFT also specified the maximum contribution from the Commonwealth - 'Health wishes to limit its exposure with respect to the total amount of capital funding involved' - and specified the maximum amounts of capital that the Commonwealth would contribute towards the purchase of PET scanners ($1.6m) and PET cyclotrons ($2.25m).

The RFT also encouraged tenderers to 'submit their best and unconditional offers in the first instance'.

The evaluation also saw tenderers assessed against the following mandatory criteria:

(a) substantive compliance with the requirements and intent of the RFT;
(b) compliance with Medicare benefits legislative arrangements;
(c) compliance with technological requirements;
(d) compliance with FDG requirements;
(e) compliance with siting requirements;
(f) compliance with timing requirements;
(g) compliance with relevant accreditation and data collection requirements;
(h) corporate capability and integrity of the tenderers; and

(i) financial capacity of the tenderer.

At all stages, the PET tender process was monitored by an independent probity adviser for its adherence to the guidelines set out in the PET tender evaluation plan.

2.2 Outcome of the Tender Process

The successful tenderers were as follows:

- Liverpool Hospital in New South Wales;
- Royal Prince Alfred Hospital in New South Wales;
- Peter MacCallum Cancer Institute in Victoria;
- Monash Medical Centre in Victoria;
- Wesley Hospital in Queensland;
- Royal Adelaide Hospital in South Australia

A notable achievement of this tender process is that 4 of these facilities have undertaken to bulk bill all patients, while the other 2 facilities will have minimum out of pocket expenses for patients.

Note: Western Australia did not submit a tender, despite the Review recommending a facility in that State. Subsequent negotiation at Ministerial level resulted in WA being offered the maximum capital available ($3.85m) for establishment of a scanner and cyclotron. WA have undertaken to have the facility operational by 1 January 2003.

2.3 Tender Evaluation in Victoria

There were 4 tenders from Victoria. Of these, two sought capital funding. One bid was compliant with the requirements of the RFT. However, the Austin's capital bid for a replacement cyclotron exceeded not only the cap of $2.25m for cyclotron funding, but also exceeded the combined cap of $3.85m for scanner and cyclotron.

At its first meeting, the Panel considered eliminating Austin's tender from the process on the basis of non-compliance with the conditions of the RFT. However, the Panel decided to seek clarification from the Austin and wrote to the Centre on 12 September 2002 pointing out that their tender exceeded the Commonwealth's cap, and asking whether their bid was conditional on receiving more than $2.25 million, and cautioning that, if their bid were conditional, the tender may be non-compliant.

The Austin's response of 21 September did not directly address the queries made, but pointed out the importance of a new cyclotron to the Austin PET facility's commercial position and research activities.

The panel sought further clarification on 25 September, specifically asking whether the Austin wished its tender to be evaluated on the basis of a bid for $2.25m.

The Austin's second response on 26 September was unclear, but did state: 'Clearly we are wishing to negotiate with you in an attempt to obtain more than the $2.25m available for a cyclotron…. If we receive only $2.25m, our PET research and development will be constrained as our income … will be reduced, but we will still be able to meet all the requirements of the tender.'

The Panel ultimately decided to assess the Austin's tender on the basis of a bid for $2.25m in capital. As a result, the Austin scored less on the capital funding criterion than the other tenderers. Its relatively high scores against other criteria did not offset its poor performance against the first criterion.

MIA Victoria and the Peter MacCallum Cancer Institute were ultimately the successful Victorian tenderers.

During a formal debrief on 1 November with the Austin, they protested that they were not given a chance to negotiate their tender. However, it was pointed out that the RFT specifically stated that any negotiations would be optional and at the Commonwealth's discretion, and also drew the Austin's attention to the RFT's 'best offer' clause.

Given that the two Victorian tenderers who were ranked above Austin were considered of a high standard, the Panel did not think it necessary to negotiate with the Austin.

3. Disallowance of 3C Legislation

Despite not being one of the preferred tenderers in Victoria, the Austin successfully lobbied for disallowance of a Health Insurance Determination, revoking a 1997 Determination enabling PET funding for the Austin and Royal Prince Alfred Hospital. The disallowance occurred on 21 March 2002. Attachment C addresses some of the issues raised during the disallowance debate.

As a result of the disallowance, the Austin is currently accessing funding at a level two and a half times greater than other PET providers.

ATTACHMENT A

Review steering committee membership

Professor Brendon Kearney
Chair

Dr Geoff Bower
Australian and New Zealand Association of Physicians in Nuclear Medicine

Dr George Klempfner
Royal Australian and New Zealand College of Radiologists

Dr Gabrielle Cehic
Royal Australasian College of Physicians

Mr Clive Deverall
Consumers' Health Forum

Dr Richard King
Ex officio member—Medicare Services Advisory Committee

Associate Professor Stephen Boyages
States and Territories representative

Professor Michael Quinlan
States and Territories representative

Mr Alan Keith
Commonwealth Department of Health and Aged Care

Dr John Primrose
Commonwealth Department of Health and Aged Care

ATTACHMENT B

MSAC supporting committee membership

Dr Richard King
Chair

Professor Brendon Kearney
Ex officio member—Chair of Review Steering Committee

Dr Michael Kitchener
Medicare Services Advisory Committee

Dr Rodney Hicks
Australian and New Zealand Association of Physicians in Nuclear Medicine

Dr Ken Miles
Royal Australian and New Zealand College of Radiologists

Associate Professor Andrew Scott
Australian and New Zealand Association of Physicians in Nuclear Medicine

Associate Professor Michael Fulham
Australian Association of Neurologists

Professor Robert Thomas
Royal Australasian College of Surgeons

Dr Michael Millward
Royal Australasian College of Physicians

Associate Professor Richmond Jeremy
Cardiac Society of Australia and New Zealand

Dr John Primrose
Commonwealth Department of Health and Aged Care

ATTACHMENT C

Issue 1 – that revocation of the Austin's Medicare funding for PET will jeopardise its important research program

Response

Firstly, the funding in question is MBS funding for clinical services only. It could not be used to fund research activities. Funding for research is available through other channels such as NHMRC grants. The Austin has accessed such research funding in the past, and is welcome to apply for such funding again.

The second crucial point is that PET is not a proven technology. A national review of PET completed in 2000 found that there is insufficient evidence from which to draw definitive conclusions about PET's clinical and cost effectiveness, and that further evaluation of the technology is required. The objective of the new arrangements introduced by the Commonwealth—of which the tender process was a part—is to effect a limited expansion of PET services, both to enhance access to a potentially valuable technology, and to enable the evaluation required before firm decisions can be made about PET's role in the Australian clinical setting.

As to the Austin's claims of pre-eminence, there were in fact three recognised centres of excellence in Australia at the time of the tender: at the Royal Prince Alfred (RPA) in Sydney, the Austin in Melbourne, and the Peter MacCallum Cancer Institute (PMCI), also in Melbourne. PMCI was a successful tenderer, as was the RPA. Located in Australia's pre-eminent cancer treatment facility, the PMCI PET facility has been in operation since 1996 and is the only comprehensive and dedicated cancer research and clinical facility in Australia. In particular, PMCI has an impressive record in clinical PET research. Among its achievements are:

- Over 6,000 clinical and research studies on more than 4,000 patients, primarily with cancer but also significant numbers of patients with advanced cardiac disease and medically refractory epilepsy.
- An ongoing research program to evaluate the clinical impact of PET in oncology.
- The publication of around 40 research papers, primarily in the field of oncology, including in such prestigious international journals as the *Journal of Clinical Oncology* (JCO 2001;19:111-118), and *Cancer* (Cancer 2001; 92:886-895).
- The establishment of in-house statistical expertise. The PMCI Statistical Centre has been actively involved in the evaluation of PET diagnostic imaging, assisting in the design of protocols and analysis and interpretation of results.
- Through collaboration with the Victorian Epilepsy Centre, a consortium comprising neurologists, neurosurgeons and ancillary staff of the St Vincent's and Alfred Hospitals, PMCI has undertaken an evaluation of PET's role in presurgical evaluation of epilepsy patients.
- Links with the Health Economics Centre of Monash University to evaluate the cost-effectiveness of PET in oncology.
- Close collaborative links with researchers in Australia, Europe and North America.

The PMCI has recently been recognised by the International Atomic Energy Association as one of the top 10 clinical PET sites in the world. As a result, the French Government has provided funding for 5 of its clinicians to train there over the next 5 years.

The RPA also has an extensive track record in clinical and research PET. It has been in operation for the same length of time as the Austin (since 1992) and received public funding along with the Austin under arrangements introduced in 1997. To date, RPA PET staff have published some 60 journal articles and book chapters, and presented papers at a number of major international conferences.

The Austin's failure to win a tender was the end result of an evaluation process which was clearly defined and documented, and which was subject to a range of rigorous checks including monitoring by independent legal and probity advisers.

While the tender evaluation process was designed to consider all aspects of a tenderer's proposal, the Request for Tender documentation made it clear that the Commonwealth's preference was for tenders requesting the least amount of capital. Although the Austin scored highly against most criteria except that of capital sought, this did not offset its poor performance against the capital funding criteria.

Issue – that the Tender Panel did not utilise their technical consultant during the evaluation

Response

The Department did not 'engage a consultant' to advise on technical aspects of the tender evaluation—although it did engage independent legal and probity advisers.

The Department saw a probable need for independent advice on strictly technical matters, primarily during the development of the tender documentation. To avoid the potential for conflict of interest in seeking such advice within the relatively small Australian PET community, the Department asked the Australian and New Zealand Association of Physicians in Nuclear Medicine to recommend an overseas expert.

The recommended individual was subsequently contacted and agreed to assist the Department when required, without remuneration. He was not out of the country during the tender process, but in fact resides in the UK.

The Department was keenly interested in the views and suggestions of this expert, but was not bound to adopt them. No issues arose requiring his advice during tender evaluation.

As to the technical expertise of the tender evaluation panel, it members included two doctors, both senior medical advisers within the Department, and one an experienced radiation oncologist.

Issue – that the Department did not fully examine the 'three options' put forward by the Austin

Response

The tender documentation made it clear that tenderers were to submit their best offer in the first instance, and that negotiation with tenderers would be at the sole discretion of the evaluation panel, and may not occur. The Austin's original tender proposal did not comply with the conditions of the tender, and their responses to the panel's subsequent attempts to clarify their tender were ambiguous. At no time were three clearly defined 'options' presented to the panel. However, even if the Austin had presented three options, in the interests of probity they would have been required to clarify the offer they were putting forward. Should the tender panel have been required to pick one option, it may have been seen as disadvantaging other tenderers who provided unambiguous responses. The Austin was given ample opportunity to clarify their tender bid and do not do so.

Issue – that revocation of the A&RMC's funding would jeopardise radioisotope supply in Victoria and South Australia

Response

The Department was aware of this issue and took into account alternative sources of radioisotope, including the National Medical Cyclotron in Sydney, and one private company, based in Victoria, currently establishing a national supply structure.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-155

OUTCOME 2: ACCESS TO MEDICARE

Topic: PRACTICE INCENTIVES PROGRAM

Written Question on Notice

Senator Chris Evans asked:

(a) How many practices are currently participating in each of the five elements of the program?
(b) Is the teaching element currently operating?
(c) What percentage of all Australian practices does this represent?
(d) What are the main reasons for non-participation in PIP?

Answer:

(a) At the May 2002 payment quarter, 4,482 PIP practices were participating in the Practice Incentives Program. Participation in the payment tiers is as follows:

PIP Tier	**No. of practices participating – May 2002**
IM/IT	
- Providing information to the Commonwealth	4,482
- Electronic prescribing	3,952
- Data connectivity	3,950
After hours care	
- Ensuring patient access to 24 hour care	4,418
- Provision of at least 15 hours of after hours care from within the practice	3,147
- Providing all after hours care for practice patients	1,302
Teaching	436
Care planning	1,000
Quality prescribing initiative	1,211
Rural loading	1,273
Asthma	3,667
Cervical screening	3,761
Diabetes	3,674
Practice nurses	793

(b) Yes.

(c) While the exact number of general practices in Australia is not known, 76% of patients* seeing a GP attend a practice that participates in the PIP. (* Measured as standardised whole patient equivalents.)

(d) The Department has not sought information from non-participating practices on their reasons.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-156

OUTCOME 2: ACCESS TO MEDICARE

Topic: PIP AFTER HOURS INCENTIVE PROGRAM

Written Question

Senator Evans asked:

(a) For FY 2001-2002 how much money was budgeted to practices participating in the PIP After Hours Incentive Program?
(b) For FY 2001-2002 how much money was paid to practices participating in the PIP After Hours Incentive Program?
(c) How many practices participate in this program?
(d) Please provide a breakdown by urban, regional and rural practices.

Answer:

(a) In the financial year 2000 – 2001 approximately $56 million was paid to practices participating in the Practice Incentive Program (PIP) after hours incentive tiers. A similar amount was expected to be expended in 2001 – 2002.

(b) In 2001 – 2002 approximately $54.3 million is expected to be paid to practices for participating in the PIP after hours tiers.

(c) In May 2002, 4,418 practices were paid for ensuring access to 24 hour care. Of these, 3,147 were also paid for provision of at least 15 hours of after hours care from within the practice, while 1,302 practices were also paid for providing all after hours care for practice patients.

(d) May 2002 payment quarter, PIP practice participation in after hours tiers by Rural, Remote and Metropolitan Area (RRMA) classification.

May 2002 Payment Quarter	RRMA 1	RRMA 2	RRMA 3	RRMA 4	RRMA 5	RRMA 6	RRMA 7
Number of practices participating in PIP	2,862	347	283	277	587	49	77
Ensuring patient access to 24 hour care – number of practices participating	2,827	341	281	270	580	45	74
Provision of at least 15 hours of after hours care from within the practice – number of practices participating	1,790	234	236	248	541	36	62
Provision of 24 hour care from within practice for patients – number of practices participating	669	85	79	99	297	16	57

Note: RRMA 1 & 2 are urban and metropolitan areas. RRMAs 3 –7 designate rural and remote areas.

PRIME MINISTER

MEDICAL INDEMNITY INSURANCE

I am today announcing further details of the Government's response to the difficulties being experienced in the medical indemnity insurance market.

The Government put in place temporary arrangements to avert a disruption in medical services when UMP/AMIL was put into provisional liquidation. Today I am announcing a substantial enhancement to the guarantee provided by those arrangements.

I am also announcing proposals for dealing with unfunded incurred but not reported liabilities (known as IBNRs). These are a particular problem for UMP/AMIL. By dealing with these liabilities, the Government will pave the way for the development of commercially sustainable medical indemnity insurance arrangements.

Key elements of the Government's strategy for ensuring that medical indemnity insurance is made a viable commercial product have been identified. The UMP/AMIL difficulties have highlighted a number of serious problems in the market for medical indemnity insurance. The Government is determined to address these problems.

Enhancement of guarantee

The existing government guarantee only covers payments for claims finalised between 29 April and 30 June 2002, and incidents that occur between 29 April and 30 June 2002.

The Government will offer a guarantee to the provisional liquidator of UMP/AMIL to enable him to:

- meet claims notified in the period 29 April to 31 December 2002 under an existing (or renewed) claims made policy;

- renew policies on a claims made basis for the period until 31 December 2002; and

- continue to meet claims that were notified before 29 April 2002 and properly payable in the period 1 July 2002 to 31 December 2002 (this is an extension of the existing guarantee that was accepted by the NSW Supreme Court last week).

Dealing with unfunded IBNRs

The Government will establish a scheme to fund currently unfunded IBNRs. Details of the scheme are as follows:

- The Commonwealth will assume liability for all unreported incidents that occurred under claims incurred policies, where there is not adequate provisioning for these liabilities. It will then recoup this liability from members of relevant MDOs over an extended period to spread payments and make them affordable.

- All MDOs will be required to participate to the extent of their unfunded IBNRs. These amounts will be the subject of independent actuarial assessment.

- The scheme will be funded by a levy on medical practitioners in those MDOs with unfunded IBNRs.

- Medical practitioners who belong to an MDO which has fully provisioned for its IBNRs will not be subject to the levy.

- Details of the levy arrangements will be developed in consultation with affected medical practitioners and the MDOs, with the aim that:

    - levies will be affordable, with amounts funded over a period of at least five years; and

    - medical practitioners will be required to contribute to the funding of unfunded IBNRs in their particular MDO.

- The scheme will also fund the extension of the guarantee to be provided to the provisional liquidator of UMP/AMIL, as set out above, to enable claims against practitioners to be paid.

Longer term strategy

The Government recognises that unless medical indemnity insurance can be made a viable commercial product, practitioners will not have the certainty they need to continue practising. This means that a number of serious problems have to be fixed. The Government has identified a number of proposals that would address these problems. Key elements of those proposals are as follows:

- Seeking the removal of NSW legislative provisions that impede the development of a commercially based medical indemnity market by capping premiums for certain high risk specialties.

- Developing arrangements, including consideration of direct financial support, to ensure premium affordability for doctors undertaking higher risk specialties.

- Working with the States to develop a suite of mechanisms that will give insurers greater certainty in calculating the size of likely claims, and assist in pricing risk and setting affordable premiums. This will have to include:

    - substantial tort law reform to contain the cost of claims, reduce the need for litigation and encourage structured settlements rather than lump sums. I welcome the substantial progress in this regard at yesterday's Ministerial meeting on public liability;

    - a range of measures to deal with the more serious, higher cost claims;

    - improved claims management; and

    - better clinical risk assessment.

- Improving transparency in the financial reporting of MDOs and bringing all of the insurance business of MDOs into the prudential framework for general insurers.

Next steps

I have instructed officials to develop the details of the longer term proposals outlined above in consultation with the States and Territories, medical practitioners and the Australian Medical Association, commercial insurers and the MDOs. It is the Government's firm intention that a new comprehensive framework of measures will be in place before 31 December 2002.

31 May 2002

SENATOR THE HON KAY PATTERSON
Minister for Health and Ageing

Dear Medical Practitioner

I am writing to you in case you are a member of United Medical Protection (UMP) practising in Australia. As you would be aware, the Boards of United Medical Protection and Australasian Medical Insurance Limited (AMIL) announced on 29 April 2002 that they will be seeking to appoint a provisional liquidator.

I understand that the Boards' announcement has led to uncertainty. Concerns have been raised as to whether doctors insured by UMP/AMIL will be covered for work they undertake in the event that the organisations go into provisional liquidation.

When a provisional liquidator is appointed to UMP/AMIL, the Commonwealth has decided that it will guarantee to the provisional liquidator, or to any subsequently appointed liquidator, the obligation of UMP/AMIL to pay any amount properly payable in respect of a claim in the period 29 April to 30 June 2002 under a current or past policy.

In addition, the Commonwealth will provide a guarantee to the provisional liquidator or to any subsequently appointed liquidator to enable the provision of cover in respect of valid claims that arise at any time for holders of:

- a current policy, for events that occur between 29 April and 30 June 2002; and

- a policy that expires and is renewed by the provisional liquidator between 29 April and 30 June 2002, for insured events that occur before 30 June 2002.

These guarantees will apply to the extent that UMP/AMIL cannot meet their obligations under these policies from their assets.

The government is committed to ensuring that these guarantees will be contractually binding on future governments. The government will legislate by 30 June 2002 to confirm the effect of the guarantee.

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On this basis I urge you to continue to provide medical services as you have done in the past.

The government has established a hotline to answer any questions you may have. The number is 1800 007 757 and the line will be open from 8:30 am to 6:30 pm Monday to Friday from Thursday, 2 May.

The government will be working with the States and Territories, medical practitioners and other interested parties including the Australian Medical Association to achieve a national outcome. This will involve developing arrangements to provide insurance for doctors into the future and to address the issue of future claims relating to incidents that occurred before 29 April 2002.

Yours sincerely

Senator Kay Patterson
Minister for Health and Ageing

1 May 2002

Commonwealth Department of Health and Aged Care

Additional Practice Nurses for Rural Australia and other areas of need

GUIDELINES

INTRODUCTION

This incentive has been designed in consultation with the nursing and general practice professions, including the General Practice Memorandum of Understanding Group (comprising the Royal Australian College of General Practitioners, the Rural Doctors Association of Australia and the Australian Divisions of General Practice), the Royal College of Nursing Australia and the National Aboriginal Community Controlled Health Organisations.

ELIGIBILITY

Is your practice eligible for the Practice Incentives Program (PIP) Practice Nurses 2001-02 Budget Initiative?

To be eligible for the Practice Nurse incentive, a practice must meet the following criteria:

1. The practice must be participating in the PIP.
2. The practice must be located within the target area, which includes:

   Rural, Remote and Metropolitan Areas Classification (RRMAs) 3-7.
   All practices located in RRMAs 3-7.

   Areas of Need within RRMAs 1-2.
   A limited number of practices in RRMAs 1-2 are located within the target area. These practices are located in population areas with a low doctor-to-patient ratio and a low socio-economic status rating (as defined by the Australian Bureau of Statistics). Only those practices in the target area will be approached by HIC to join the program.

   Aboriginal Medical Services (AMS).
   All AMSs participating in the PIP and located in RRMAs 1-7.
3. The practice must employ or retain the practice nurse for the minimum number of sessions required.

   Please note: your practice may wish to employ an Aboriginal Health Worker (AHW) in place of, or as well as, a practice nurse. If this is the case, please contact HIC on 1800 222 032 for an information package and application form.
4. The minimum employment requirement for the practice nurse is dependent upon the size of the practice. Regardless of size, however, the practice must employ or retain the services of a practice nurse for a minimum of two sessions per week, averaged over each PIP payment quarter.

   Note: for the purposes of the PIP Practice Nurses incentive, a session is to be 3.5 hours as a minimum.

SWPE PER PRACTICE	MINIMUM SESSIONS NURSE REQUIRED TO WORK PER WEEK AVERAGED OVER THE PIP PAYMENT PERIOD
0-1499	2
1500-1999	3
2000-2499	4
2500-2999	5
3000-3499	6
3500-3999	7
4000-4499	8
4500-4999	9
5000 or more	10 (full time)

The minimum requirement of a larger practice will be determined by its SWPE value. The employment requirement increases by one session for each additional 500 SWPEs, rounded down, as shown in the table above:

The period of employment is inclusive of all personal leave and recreation leave. Provision has been made for a 21-day recruitment lag. This means that if your practice nurse's employment ceases; you are allowed 21 days to make other arrangements for a replacement without your quarterly payment being affected.

5. All eligible practices, regardless of size, have an opportunity to participate in the scheme. As with most other PIP components, payments are based on numbers of SWPEs.

   The incentive payment is capped at a maximum of 5000 SWPEs per practice, which would require a practice to employ or retain one full time nurse (ie 10 sessions per week).

6. The nurse may be either a Registered Nurse or an enrolled nurse and must be registered with the relevant registration board of the State/Territory in which they are employed.

7. The nurse must have the minimum specified qualifications appropriate to the functions undertaken. Professional nursing standards require that an Enrolled Nurse must be supervised by a Registered Nurse. Supervision may be direct or indirect, but appropriate supervisory arrangements must be in place.

8. The practice nurse must predominantly be employed in undertaking functions from the list at Attachment A during the relevant employment period.

How does your practice enroll for the PIP Practice Nurse incentive?

Practices that employ nurse/s and meet the above eligibility criteria can apply.

A separate application form is enclosed with these guidelines. This is to be completed, signed by the authorised contact person and returned to HIC. By submitting this form, you are confirming your eligibility and that you understand your obligations to HIC, including notifying HIC if the practice nurse employment arrangements within your practice change.

How can you receive payment in the February 2002 PIP payment run?

The practice must employ or retain the services of a practice nurse for a period equivalent to its minimum requirement (according to its SWPE count) during the period November 2001 – January 2002 inclusive and return the application form to HIC for processing by 14 January 2002. If the form is returned after 14 January 2002, payment will

commence in the May 2002 PIP payment. Back payments will not be made for previous payment periods. HIC will process all application forms received after 14 January 2002 for the May quarterly payment relating to the period February 2002 – April 2002.

How much do you receive?

The level of the incentive is designed to encourage practices to employ or retain the services of nurses and is not intended to cover the full cost of employing a practice nurse.

Incentive payments will be calculated on a dollar amount per SWPE.

An annual incentive equivalent to at least $8.00 per SWPE will be paid to all practices that meet the eligibility criteria. This will be calculated as $7.00 per SWPE for practices in RRMAs 3-7. The payments in these RRMAs attract the standard PIP rural loading, meaning a payment of $8.05 in RRMA 3 and higher amounts in other rural areas according to remoteness.

Practices in RRMA 1-2 will receive payment of $8.00 per SWPE (no rural loading is applied to practices in RRMA 1-2).

How will the payment be made?

Payment will be made by HIC to eligible practices as part of each quarterly PIP payment.

If the practice satisfies the eligibility criteria for a full PIP payment quarter, the practice will receive a PIP payment equal to approximately one quarter of the annual incentive amount at the end of that quarter.

Is your practice eligible for the rural loading?

Practices located in RRMA 3-7 inclusive are eligible for the standard rural loading applied to PIP payments. HIC will calculate the loading automatically when calculating payments.

What does it mean to your payment if your practice nurse resigns?

Incentive payments can only be made to a practice that can demonstrate that it has employed or retained the services of a practice nurse for a period of time equivalent to its minimum requirement (based on its SWPE count) in each PIP payment quarter.

A practice may decide to retain the services of a practice nurse full-time during only part of a PIP payment period to provide a specific service (eg health promotion activities or immunisation). The practice's minimum requirement would be deemed to be met if the aggregate period of time worked by the practice nurse was equivalent to the number of weekly sessions required of the practice (based on its SWPE count).

Example: practice A has a SWPE count of 1320. It is therefore required to employ or retain a practice nurse for two sessions per week to be eligible. The practice understands that it must employ a practice nurse for any 26 sessions over a 13 week quarter to maintain its eligibility.

What are your obligations?

1. You are required to notify HIC if the practice nurse's employment falls below the minimum requirement during the quarter relating to the PIP payment cycle. You will be informed of your practice's minimum requirements with each PIP payment statement.
2. You are required to ensure that the practice nurse has a clear, unambiguous and agreed role description consistent with the qualifications of the nurse and the legislative framework of your state or territory.
3. You are required to ensure that the practice nurse has support systems, such as access to training and de-briefing, and peer mentoring opportunities that recognise the geographical issues of the practice location.
4. You are required to maintain employment records relating to the practice nurse. These records may be required to demonstrate employment history under the HIC PIP Audit Program.
5. You are required to ensure the registration qualifications of the practice nurse are current at all times. Evidence of this may be required under the HIC PIP Audit Program.

ATTACHMENT A

THE ROLES AND FUNCTIONS OF THE PRACTICE NURSE WITHIN GENERAL PRACTICE

The functions to be undertaken by the practice nurse include the following. To be eligible for incentive payments nurses must undertake functions from within this range during the minimum employment period.

Providing clinical nursing services in the general practice context through:

- Triage.
- Assessment.
- Therapeutic care and treatment.
- Diagnostic services.
- Clinical data management.

Coordinating patient services through:

- Networking with other services.
- Integrating service delivery.
- Planning and management of care.
- Providing information and feedback between the services, patients and GP.
- Patient advocacy.

Managing the clinical environment by assisting general practice to meet relevant standards and legislative requirements in:

- Infection control.
- Cold chain monitoring.
- Records management.
- Occupational health and safety.
- Accreditation processes.

Promoting patient, carer and community well being through:

- Health information.
- Education.
- Specific programs.
- Community development.
- Self care.

Sustaining general practice by contributing to better management of human and material resources through:

- Optimising the use of professional resources.
- Building the practice base.
- Building practice capacity to adapt to change.
- Maximising financial efficiency.

Improving health outcomes by contributing to and enhancing the management and prevention of ill health through:

- Health screening.
- Immunisation.
- Recall.
- Patient education.
- Outreach services.
- Systems management.
- Acute and chronic disease management.

DEC 2001