Community Affairs
Legislation Committee

Examination of Budget Estimates 2002-2003

Additional Information Received

VOLUME 4

Outcomes 3 - 9

HEALTH AND AGEING PORTFOLIO

OCTOBER 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

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-239

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: SAVINGS IN THE BUDGET MEASURE

Hansard Page: CA347

Senator Evans asked:

How much saving is due to having fewer beds online than anticipated? I would be interested in the comparison between your estimates and what we ended up with as beds online.

Answer:

Due to the complexity of the residential care forward estimates model it would require considerable diversion of resources to explore this query. However, in effect there is no saving since the Government subsidises whatever is the number of residents in aged care homes.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-240

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RESPITE CARE

Hansard Page: CA 349

Senator Denman asked:

Could I have the guidelines for the approval of respite care centres?

Answer:

These are set up on a regional basis to arrange or purchase respite care for people requiring respite. There are some 95 Carer Respite Centres (including multiple outlets) across 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: E02-037

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ACCREDITATION FEES FOR NURSING HOMES

Written Question on Notice

Senator Allison asked:

Is it true that an accreditation fee for a nursing home would be in the vicinity of $130 per resident (eg $13,000 for a 100 place nursing home) and if so why is it so high?

Answer:

The accreditation audit fee schedule is outlined in sections 2.6 and 2.7 of the Accreditation Grant Principles 1999.

The Government provides a 100% accreditation fee subsidy for services with less than 20 places. This means that services with between 1 and 19 places are not required to pay any fees for accreditation.

Services with between 20 and 25 places receive a tapered subsidy.

No service pays an accreditation fee greater than $12,550, regardless of the size of the home.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-038

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NURSING HOME INSPECTIONS

Written Question on Notice

Senator Allison asked:

Why are nursing homes advised of inspections in advance. Are you not concerned that everybody will put on their best face to perhaps make the facility look far better that it does on a regular daily basis, thus giving the Government a false impression?

Answer:

Many visits are carried out without notice however there are certain circumstances where an aged care home must be given notice.

For example, the Principles under the *Aged Care Act 1997* (the Act) require that the Aged Care Standards and Accreditation Agency assessors give notice of a site audit. Approved providers can then inform residents and relatives when a site audit will occur and that they have an opportunity to talk with members of the Agency assessment team. During the site audit the assessment team is required to meet with at least ten percent of the residents (or their representatives) to discuss the site audit.

The Agency also conducts support contact visits to homes to ensure ongoing compliance with the Accreditation Standards. These visits may be conducted as a 'spot check' where less than 30 minutes notice is given prior to the assessment team entering a home.

Review audits may also be conducted as a 'spot check' by the Agency. A review audit may be conducted under particular circumstances, such as where there is reason to believe that a home may not be complying with the Accreditation Standards.

The Department of Health and Ageing (the Department) has responsibility to ensure that approved providers meet all of the obligation under the Act and the Principles under the Act. Authorised officers from the Department may undertake spot checks at a home without notice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-039

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE SERVICES - PUBLIC LIABILITY

Written Question on Notice

Senator Allison asked:

(a) Is it true that aged care service providers will be hit with massive cost increases - as much as 250% - in public liability insurance?
(b) Is the level of insurance required a fixed condition of Government funding? Does it necessarily reflect the actual risk profile of such services?
(c) Is the funding specifically increased to take account of such significant shifts in business costs to providers?
(d) What about organisations that attempt fund raising to meet increased costs then are faced with increased insurance charges for these events as well?

Answer:

(a-d) In the 2002-03 Budget the Government committed $7.2 million over two years to conduct a comprehensive review of the pricing arrangements in residential aged care. The Review will examine long-term financing options for the aged care sector and will take into account the improved care outcomes that are now required under accreditation and underlying cost pressures impacting on the industry. This will include increases in workers' compensation and other insurance premiums.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-040

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: VOLUNTEERS INSURANCE

Written Question on Notice

Senator Allison asked:

Is the Department aware of the unwillingness of insurance agencies to cover the work of volunteers over the age of 65 or 70, especially for Meals on Wheels services?

Answer:

The Department is not aware of problems with insurance cover for volunteers working in the residential aged care or community care sectors

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-041

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE PROVIDERS - FRAUD INSURANCE

Written Question on Notice

Senator Allison asked:

Given that providers are also facing increases in fraud insurance - up to 800% are reported in some facilities where no claim has been made and which the government requires residential care providers to hold regardless of actual risk. Has any thought been given to action such as bulk purchasing of public liability for funded agencies or increasing government funding to recognise the cost to services.

Answer:

In the 2002-03 Budget the Government committed $7.2 million over two years to conduct a comprehensive review of the pricing arrangements in residential aged care. The Review will examine long-term financing options for the aged care sector and will take into account the improved care outcomes that are now required under accreditation and underlying cost pressures impacting on the industry. This will include increases in workers' compensation and other insurance premiums.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-105

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE BUDGET

Written Question on Notice

Senator Evans asked:

Can the Department please provide a detailed breakdown program by program of the Aged Care Budget, including forward estimates (Details in the Budget material are too vague.)

Answer:

Under the accruals budgeting framework introduced by the Government in 1999-2000, funding is appropriated by Outcome and reported by Outcome, Administered Item and Bill Number in the annual Portfolio Budget Statements. Funding is neither appropriated nor reported by program. This arrangement gives the Minister greater flexibility to manage aged care programs and to re-align funding if and as priorities change.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-106

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RESIDENTIAL AGED CARE SUBSIDIES

Written Question on Notice

Senator Evans asked:

When was the Department aware that there would be an underspend in the residential aged care subsidies for 2001-02?

Answer:

The Department estimates annual residential care subsidies and supplements using a model, which incorporates economic and other parameters/cost drivers The estimates are reviewed on a regular basis throughout the year as parameters and cost drivers are updated and as the results of the model are compared against expenditure trends.

The Department was aware in the first half of the 2001-02 financial year that expenditure was trending below estimated spending forecasts. However, these early indications did not necessarily point to an underspend for the year, due to the anticipated impact of Budget measures relating to payroll tax and viability supplement that were expected to take effect in the second half of the financial 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: E02-116

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RESIDENTIAL AGED CARE SUBSIDY

Written Question on Notice

Senator Evans asked:

With reference to the increased Residential Aged Care Subsidy Measure:

(a) How will this year's money ($50 million) be allocated?
(b) Where did the actual amount come from?
(c) How were the costings done?
(d) Was the Department aware that this would only result in an extra $1 per day per resident?
(e) Is the $50 million to only cover existing residents?
(f) Will the remaining $161 million only be spent when the Review is completed?

Answer:

(a) The additional funding of $50 million (indexed) per annum for residential aged care subsidies involves an increase in basic subsidy rates, over and above the increases that will flow on from normal indexation, as follows:
- 1.5 per cent in the basic subsidy rates for RCS categories 1-4; and,
- 0.75 per cent in the basic subsidy rates for RCS categories 5-7.

(b) During the election, the Government promised $200 million over four years to increase residential aged care subsidies, pending the outcome of a review of the pricing arrangements for residential aged care.

(c) Given the election commitment promised $200 million over four years ($50 million per year) to assist aged care providers with workforce issues, the greater proportion of the funding has been directed towards high care subsidies i.e. RCS categories 1-4.

(d) The measure provides for an increase in residential aged care subsidies, over and above annual indexation, of 1.5 per cent for RCS categories 1-4 and 0.75 per cent for RCS categories 5-7.

(e) Residential aged care subsidies, incorporating the increase, will be paid for all residents from 1 July 2002.

(f) No, as the increase to subsidies has been incorporated into the forward estimates model, the additional funding will flow through from year to 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: E02-107

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RESIDENTIAL AGED CARE SERVICES

Written Question on Notice

Senator Evans asked:

With reference to the Statement in the Budget that $174 million will be saved in the 2002 - 03 Budget due to "a fall in estimated demand for residential aged care services", I ask:

(a) When did the Department of Health and Ageing inform the Department of Finance that there had been a fall in expenditure on residential aged care subsidies?
(b) How was this done? Or did the Department of Finance inform the Department of Health and Ageing that there had been a fall in expenditure? - If so when and how was this done?
(c) Did the Department and/or Minister suggest to the Department of Finance that the reason for the decrease in residential aged care subsidy estimates was because of a "fall in estimated demand for residential aged services and a downward revision to estimated dependency levels? - If not where did this wording come from? - Does the Department believe this to be true? If not why wasn't it corrected?
(d) When did the Department realise that there would be an underspend last year? - Did the Department/Minister make any effort to have this money redirected into other Aged Care programs?
(e) If the Department did know that there would be an underspend, from what information/research did they obtain that information?
(f) Was the information gathered from the most recent stocktake use for this analysis?
(g) Was there any suggestions from either the Department of Health and Ageing or the Minister that the Government's predicted savings of $174 million in the coming year could be diverted into other Aged Care programs ? If so how and when was this done?

Answer:

(a) During the first half of 2001- 02.

(b) Discussions with the Department of Finance.

(c) Budget Paper No. 1 which is quoted is developed by the Treasury and the Department of Finance.

(d) See answer (a) above. A change in estimates is not an underspend for use in other aged care areas.

(e) The Department continually monitors expenditure.

(f) The residential care forward estimates were updated at Additional Estimates and at Budget and reflected the latest available data for economic parameters and cost drivers at those times.

(g) See answer (d) above.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 5 & 6 June 2002

Question: E02-108

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ALLOCATION OF PLACES IN 1998

Written Question on Notice

Senator Evans asked:

(a) How many places were allocated in 1998?
(b) How many places allocated in the 1998 round are now operational?
(c) What is the break down – high care? low care and extended care?

Answer:

Places Allocated in 1998

High Care	Low Care	Total Residential	Community Aged Care Packages	Total
285	**1981**	**2266**	**3657**	**5923**

Data on operational places is being updated and will be provided at a later stage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 5 & 6 June 2002

Question: E02-109

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ALLOCATION OF PLACES IN 1999

Written Question on Notice

Senator Evans asked:

(a) How many places were allocated in 1999?
(b) How many places allocated in the 1999 round are now operational?
(c) What is the break down – high care, low care and extended care?

Answer:

Places Allocated in 1999

High Care	Low Care	Total Residential	Community Aged Care Packages	Total
395	**2551**	**2946**	**4275**	**7221**

In accordance with the *Aged Care Act 1997*, providers have up to two years for beds to become operational.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 5 & 6 June 2002

Question: E02-110

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ALLOCATION OF PLACES 2000

Written Question on Notice

Senator Evans asked:

(a) How many places were allocated in 2000?
(b) How many places allocated in the 2000 round are now operational?
(c) What is the break down – high care, low care and extended care?

Answer:

Places Allocated in 2000

High Care	Low Care	Total Residential	Community Aged Care Packages	Total
589	**7280**	**7869**	**6535**	**14404**

In accordance with the *Aged Care Act 1997*, providers have up to two years for the beds to become operational.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 5 & 6 June 2002

Question: E02-111

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ALLOCATION OF PLACES IN 2001

Written Question on Notice

Senator Evans asked:

(a) How many places were allocated in 2001?
(b) What is the break down – high care, low care and extended care?

Answer:

Places Allocated in 2001

High Care	Low Care	Total Residential	Community Aged Care Packages	Total
2041	4245	6286	1711	7997

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-112

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: ALLOCATED PLACES – 1997-2000

Written Question on Notice

Senator Evans asked:

(a) Can the Department separately indicate for the years 1997, 1998, 1999, 2000 how many allocated places have not been made operational by State, differentiating nursing home and hostel places.
(b) Can the Department separately indicate for 1998, 1999, 2000 how many extensions were granted for places to be made operational.
(c) What were main reasons why extensions were needed?

Answer:

(a) Data on operational places is being updated and will be provided at a later stage.

(b) The information for earlier years is not available in an easily retrievable form and represents an inappropriate diversion of resources.

(c) For the provisional allocations remaining in December 2001, and for which extensions had been approved, the main reasons given by the Approved Providers for the extension being requested were, in order of frequency:

- obtaining local government approvals and appeals against local government decisions, and
- Approved Provider priorities for example constructing the places in sequence and moving residents within the residential aged care facility, or receiving a subsequent allocation of places and undertaking construction for both provisional allocations in conjunction.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2002-2003, 5 & 6 June 2002

Question: E02-113

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: OPERATIONAL PLACES

Written Question on Notice

Senator Evans asked:

In Additional Estimates 2000-2001 Senator Evans asked about the aged care places per 1,000 people aged 70 and over by the year 2002. The Department provided its latest estimate on the number of operational places per 1,000 people aged 70 and over in 2002 as 175,000.

(a) What is the current figure?
(b) What is the current ratio of operational places per 1,000 over the age of 70?
(c) Please provide by region break down.

Answer:

Data on aged care places for 2001/02 will appear in the Department's Annual Report.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-114

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RURAL AND REGIONAL NURSING HOMES

Written Question on Notice

Senator Evans asked:

(a) Is the Department aware that the Government promised during the election that they would spend $25 million each year for the next four years on upgrading rural and regional nursing homes so that they could meet fire and safety standards?
(b) Given that it was a Government promise why then was a decision made to spend only $78. 8 million over the next four years? Who made that decision?
(c) Was advice given to the Minister before the election about the time it would take to roll out the program? How was this done? Was different advice given to the new Minister? Why? How was this done?
(d) What are the reasons for the delay in the money rolling out? When did the Department become aware of these issues?
(e) How is the money being guarantee for years 5 and 6?

Answer:

(a) Yes.

(b) In any building program there are time lags between the allocation of grant funds for the capital works and when the expense is actually incurred. $77.1 million of the committed funds (the other $1.7 million represents the cost of administration) for capital grants will be spent in the next four years with the remaining funds spent in the following two years. This is normal practice for capital works projects.

(c) The Government was aware that while $100m may be allocated over the next 4 years, the nature of capital works is that it would be spent over a longer period.

(d) See (b) and (c).

(e) Under the accrual based budgeting framework the outstanding commitments to be expensed in 2006-07 and 2007-08 that relate to approved capital grants allocated in the current budget and forward estimate period will be accounted for in the estimates of cash requirements for those years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-115

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PRICING REVIEW

Written Question on Notice

Senator Evans asked:

With reference to the Pricing Review announced in the Budget, I ask:

(a) What is the timeframe for the pricing review?
(b) What are the main aims of the Review?
(c) What are the Terms of Reference for the pricing review?
(d) How broad will the Review be? For example will it look at thing such as the planning ratio, paperwork, workforce issues?
    i. If yes how will it do that?
    ii. If No, why not? - How can any review not include such issues?
(e) How much of the $7.2 million over the two years will be out sourced to consultants?
(f) Will the Review be presented to Minister Andrews ?
(g) Is it expected that other Ministers will be involved?
(h) Will the Department of Finance have a role in the Review?
(i) What consultations have taken place with the Community Sector regarding the Term of Reference for the Review?

Answer:

(a) The Government has committed $7.2 million over two years to conduct a review of the pricing arrangements in residential aged care.

(b) The Review will examine long-term financing options for the aged care sector and will take into account the improved care outcomes that are now required under accreditation and underlying cost pressures, including movements in nurses' and other wages, and increases in workers' compensation and other insurance premiums.

(c) The Terms of Reference for the review are still to be determined and will be announced early in 2002-03 after consultation with the industry.

(d) See (b).

(e) This is yet to be decided.

(f) Yes.

(g) Consultation with other Portfolios is anticipated.

(h) See (g).

(i) The Minister has held informal discussions with a number of organisations and peak bodies in relation to the Review. Formal consultations will take place in the near 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: E02-117

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE NURSING SCHOLARSHIPS

Written Question on Notice

Senator Evans asked:

With reference to the 26.3 million allocated in the Budget for more Aged Care nurses I ask:

(a) How does the Government intend to ensure that the $26.3 million it has allocated to fund up to 250 scholarships, valued at up to $10,000 a year for students from regional areas to do undergraduate, postgraduate or re-entry nursing studies at rural and regional university campuses – that even half of them end up working in Aged Care?
(b) When will these scholarships become available?
(c) How will they be distributed? Have high needs areas been identified? If not why not?
(d) Does the Commonwealth have agreements with certain Universities?
(e) Where are these Universities?
(f) How will the scholarships be advertised?

Answer:

The Initiative will be guided by the Aged Care Workforce Committee and will be implemented after appropriate consultation with the Committee.

The experience of the Australian Remote and Rural Nursing Scholarship Scheme will be used.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-118

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: FUNDING FOR ACCREDITED COURSE IN GERIATRIC CARE

Written Question on Notice

Senator Evans asked:

The government will be providing funding of $21.2 million over four years so personal care staff in smaller, less viable aged care homes can do a range of accredited courses related to geriatric care. There is some concern that this money is not tied and that the $21.2m will go to providers of aged care but no guarantee that it will be used for that purpose.

(a) What guarantee will be sought from organisations to use the money as intended?
(b) How will the Government monitor this expenditure?
(c) Is there any accountability for this?
(d) Also how was the money calculated? – for example in the NT, the salary differentiation is 14% between the public and private sector, let alone any comparison with interstate salaries.
(e) Will the money be given on a priority basis? Will it be by submission or tender?

Answer:

This initiative will be guided by the Aged Care Workforce Committee and will be implemented after appropriate consultation with the Committee.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-119

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: STAFF SHORTAGES IN AGED CARE FACILITIES

Written Question on Notice

Senator Evans asked:

What are the Government's immediate plans to address the staff shortages in residential aged care facilitates?

Answer:

In the 2002-2003 Budget the Government announced that it would be putting in place several initiatives to support the aged care workforce.

The Government is providing $50 million per annum (indexed) to respond to issues such as wage pressures. The Government will also be undertaking a Pricing Review of Aged Care which will take into consideration a broad range of issues including workforce issues.

The Government is also providing $47.5 million over four years to provide scholarships to encourage more nurses to enter or re-enter the aged care sector and to provide care staff with opportunities to upgrade or enhance their skills.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-120

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NURSES AND CARE STAFF

Written Question on Notice

Senator Evans asked:

Is the Department working on any modelling to gauge the number of nurses and care staff that will be needed in the future?

Answer:

The Aged Care Workforce Committee will be overseeing the development of a National Aged Care Workforce Strategy that will consider the needs of that sector both presently and into 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: E02-121

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: SPECIALIST VOLUNTEER CARERS

Written Question on Notice

Senator Evans asked:

(a) What research has the Department already carried out or is aware of that looks at the role of specialist volunteer carers? Does the Department know for example – how many volunteers there actually are?
(b) Is the department aware of any research that might indicate that volunteers are a reliable source of support to assist ageing carers?
(c) Does the department believe that volunteers are an appropriate response to the support needs of older Australians who care for people with disabilities? How much money will be spent on the pilot program?

Answer:

(a) The Department of Health and Ageing is aware of work undertaken by Carers Australia on the use of volunteers and of documents produced by Volunteering Australia relating to standards and best practice management for volunteer programs. The Department is also aware of the positive findings of evaluations of the Commonwealth funded Volunteer Management Program in 1995 and 1998.

Volunteering Australia have estimated that one in five Australians participate in some form of volunteer work. Volunteers can be found working in a wide range of areas, including emergency services, sport and recreation groups, health and welfare organisations, libraries and museums.

(b) The Department is not aware of any specific research on the issue of reliability of volunteers as a source of support to assist ageing carers.

(c) The Department does not believe that volunteers alone are an appropriate response to the support needs of older Australians who care for people with disabilities.

Up to $10 million over four years will be available for the development and implementation of the specialist volunteer pilot program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-122

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CARE PACKAGES FOR AGEING CARERS

Written Question on Notice

Senator Evans asked:

(a) How much money will be available to purchase care packages for ageing carers of people with disabilities?
(b) What investigations has the department undertaken about the availability of such packages across Australia – even with money being provided?

Answer:

(a) About $10 million over four years.

(b) All Commonwealth Carer Respite Centres currently have brokerage funds they can use to purchase single services or packages of respite care for carers. These funds are available to help carers of any age of people with disabilities as well as carers of the frail aged, people with dementia and others.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-135

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PEAK ORGANISATIONS

Written Question on Notice

Senator Evans asked:

Can the Department provide a breakdown of what peak organisations they will directly fund in 2002 – 03. And how much they will fund each organisation, purpose of funding and when their funding is up for reconsideration?

Answer:

A number of ageing related peak organisations are funded under the Community Sector Support Scheme (CSSS) which provides funding to secretariats of national peak community based organisations which focus their efforts on activities relevant to the health and ageing needs of the Australian community. Organisations funded through this avenue are tied to the achievement of specific outputs within individual annually negotiated Funding Agreements. These outputs cover the areas of policy, representation, information dissemination and governance. The next annual reviews of funded organisations will take place in April/May 2003.

The Ageing related organisations funded under CSSS in 2002-2003 are as follows:

Carers Australia	$321,482
Council on the Ageing, Australia (COTA)	$321,482
Aged & Community Services Australia (ACSA)	$138,569
Alzheimer's Association of Australia	$138,569
Continence Foundation of Australia (CFA)	$138,569

In addition, a wide range of organisations, including some that are peak bodies, receive funding through the Ageing and Aged Care Division for the delivery of specific services. These arrangements are unrelated to the role of the organisations as peak bodies.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-136

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: COUNCIL ON THE AGEING AND NATIONAL SENIORS ASSOCIATION

Written Question on Notice

Senator Evans asked:

(a) Is the Department aware of the planned merger between the Council on the Ageing (COTA) and National Seniors Associations?
(b) Will this impact on COTA's funding?
(c) What is the Department's view on the merger?

Answer:

(a) Yes.

(b) Negotiation of the COTA grant for 2002-03 through the Community Sector Support Scheme is proceeding through the normal process.

(c) The Department is supportive.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-128

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE PROGRAMS

Written Question on Notice

Senator Evans asked:

(a) Has the Department previously provided the Minister with a briefing about the ageing population and the likely impact on program advision [sic] by the Aged and Community Care Division?
(b) What advice did the Department give about the likely impact on these program costs?
(c) How was this advice given?

Answer:

(a-c) The Department regularly provides advice to the Minister on the likely impact of an ageing population.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-134

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL STRATEGY FOR AN AGEING AUSTRALIA

Written Question on Notice

Senator Evans asked:

What are the next stages for the National Strategy for an Ageing Australia?

Answer:

The National Strategy Framework document identifies key issues, a number of goals and some broad, practical actions to meet these goals. It provides a basic framework to address current issues facing older people and to prepare for future demographic changes as Australia's population ages over the next 50 years. It also highlights that the ageing of Australia's population is an issue for all Australians - governments, businesses, community organisations, and individuals.

The framework document is being used to engage the community on the issue of ageing, with a series of community discussions being held by the Minister for Ageing around Australia. The outcomes of these discussions will be part of informing the next steps of implementing the National Strategy. Consultations with peak business, community and professional groups are also scheduled to be held in the near future.

Current Commonwealth initiatives include the Intergenerational Report, the development of a mature age workers strategy, and the development of legislation to prohibit discrimination on the basis of age.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-123

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL STRATEGY FOR AN AGEING AUSTRALIA

Written Question on Notice

Senator Evans asked:

(d) Why was there no mention about the National Strategy for an Ageing Australia in the Budget Material?

(e) What is the total amount the Government has spent on research to date for the development of the National Strategy for an Ageing Australia?

Answer:

(a) The National Strategy for an Ageing Australia was, for example, an integral component of Budget Related Paper 11, Portfolio Budget Statement 2001-02, Health and Aged Care Portfolio.

(b) The Government provided $6.1 million in the 2000-01 Budget over four years (Portfolio Budget Statement 2000-2001, page 109) to enable the implementation of a range of partnership initiatives to support 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: E02-137

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PRODUCTIVE AGEING CENTRE

Written Question on Notice

Senator Evans asked:

(d) Why was the University of Sunshine Coast chosen as the host for the establishment of the Productive Ageing Centre?
(e) What was the process?
(f) Were other universities considered? Which ones and why were they not deemed suitable?
(g) What role did the University's relationship to the National Seniors Association play in determining the location of the Centre?
(h) How will the Productive Ageing Centre 'introduce programs to enhance productive ageing' – as was stated in the Budget papers?

Answer:

(a) This measure reflects an election commitment to contribute to a Productive Ageing Centre which the National Seniors Association is establishing at the University of the Sunshine Coast.

(b) See (a).

(c) See (a).

(d) See (a).

(e) The details of the outcomes to be delivered and how they will be delivered by the Productive Ageing Centre will be subject to negotiation between the Department and the National Seniors Association and documented in the funding agreement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-138

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PRIMELIFE

Written Question on Notice

Senator Evans asked:

(a) Is the Department still satisfied with the financial viability of Primelife?
(b) What checks has the Department carried out since this was raised at Senate Estimates in May 2001?
(c) Is the Department monitoring the number of complaints it is receiving from current residents in Primelife facilities? How are they doing that?

Answer:

(a-b) The Department has carried out regular checks of information publicly available from the Australian Securities and Investments Commission. In addition, the Department has utilised independent financial probity and credit/debt information. Primelife has submitted Prudential Compliance Statements for the 2000/2001 financial year in October and November 2001 which satisfy the requirements of the *Aged Care Act 1997* and *Aged Care Principles 1997*.

(c) The Department receives and monitors complaints received in relation to all approved 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: E02-139

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS
Topic: CARELINK

Written Question on Notice

Senator Evans asked:

(a) How much funding is spent each year on the Carelink initiative?
(b) Does the Department monitor the number of inquires?
(c) Can the data collected by these services be made available? If yes, please provide. If no why not?
(d) Does the Department believe they are having a positive impact?
(e) What are the Department's concerns about the Centres?
(f) Does the Department plan to expand the services?

Answer:

(a) Funds spent so far are as follows:

1999/2000	2000/2001	2001/2002
$ 3,632,107	$ 11,922,310	$ 12,801,939

(b) Yes.

(c) A booklet outlining preliminary data is currently being produced reporting on first year data collection 1 May 2001 to 30 April 2002.

(d) Yes. National Client usage is steadily increasing to now over 10,000 contacts per month.

(e) Greater use by general practitioners will be encouraged.

(f) Any expansion is a matter for Government to consider.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-140

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE SERVICE PROVIDERS INSURANCE

Written Question on Notice

Senator Evans asked:

(a) What analysis is the Department undertaking about the increase in insurance costs and its impact of Age Care service providers?
(b) How does the Department believe it will impact on Aged Care service providers?
(c) Is the Department aware of concerns from the industry about increased insurance costs?
(d) How will the Government protect frail older people from the impact of insurance costs increases on aged and community care services?

Answer:

(a-d) In the 2002-03 Budget the Government has committed $7.2 million over two years to conduct a comprehensive review of the pricing arrangements in residential aged care. The Review will examine long-term financing options for the aged care sector and will take into account the improved care outcomes that are now required under accreditation and underlying cost pressures impacting on the industry. This will include increases in workers' compensation and other insurance premiums.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-141

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CONSULTANCIES

Written Question on Notice

Senator Evans asked:

The Department engaged consultants at least twice in the last year or so to look at consumer communications issues.

(a) What happened to their reports? Have these reports been released? If not, when and how will they be released?
(b) How much was spent on these reports?
(c) What were the main findings?

Answer:

Worthington Di Marzio were engaged in June 2000 to conduct research into the information needs of aged care consumers.

(a) An internal report for the Department was received in May 2001.

(b) The consultancy cost $148,060 including GST.

(c) Some communication insights gained from this research were:

- Some consumers are under-informed and do not plan adequately for their future aged care needs;
- Opportunities exist to boost awareness of the Aged and Community Care Information Line, the Commonwealth Carelink Centres, the Aged Care Complaints Resolution Scheme and the Age Page in the White Pages directory;
- People are most likely to seek information about aged care services from their local practitioner.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-142

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS
OUTCOME 6: HEARING SERVICES

Topic: CONSULTANCIES

Written Question on Notice

Senator Evans asked:

Can the Department provide us with a list of all consultancies used by the Aged Care Division over the last two years with the status of the report ie in progress, released, not released. – This info is not in the annual report.

Answer:

Please see attached annotations to excerpts of the 1999/2000 and 2000/2001 Department of Health and Aged Care Annual Reports.

Source: **Department of Health and Aged Care Annual Report 1999/2000, Appendix 8 "Consultancy Services"**

Outcome 6: Hearing services

Consultant	Status of report
Centre for International Economics	Not released.
Vivienne Tippett and Associates	Not released.

Outcome 8: Enhanced quality of life for older Australians

Consultant	Status of report
Moodie and Associates	Completed – directory released.
University of Sydney	Completed – report released.
Equanimity Consultants Pty Ltd	Completed July 2000. No final report required.
Access Economics	Completed.
Turnbull Porter Novelli	Completed.
Worthington Di Marzio	Final report received, not intended for public release.
Quay Connection	Project completed.
Bearcage Productions	Video released.
Dangar Research Group Pty Ltd	Used in development of the above video.
Niki Ellis & Associates	Released.
Toni McDowell copywriting & Graphic Design Management	Not released.
Pam Pryor & Associates Pty Ltd	New processes developed and training delivered, in place for the 2000 awards.
Hammond Care Group	Package for industry released.
Mioche and Associates	Reporting system developed and released.
Rosalind Dey	Protocols developed and released.
Royal College of Nursing Australia	Finalised.
School of Nursing, La Trobe University	Report received and used for ongoing work.
Phillips Fox	Finalised.
Siggins Miller	Finalised.
Bearcage Productions	Finalised and released.
Consultant	**Status of report**
Walter and Turnbull	Training completed.
Mioche and Associates	Final kit received.
National Key Centre for the Social Applications of Gis (GISCA) *contract is between the Department and Luminis Pty Ltd*	New Viability Funding Arrangements implemented.
Alt Beatty Consulting	Finalised.
Alt Beatty Consulting	Finalised.
Hammondcare Group (Mr Richard Fleming)	Not released.
National Geographic Information Systems Australia P/L	Finalised.
Continence Foundation of Australia	In progress.
Jenny Pearson & Associates Pty Ltd	Finalised.
Continence Foundation of Australia	Finalised.
Jenny Pearson & Associates Pty Ltd	Finalised.

Ovens & King Community Health Service Inc	Finalised.
Continence Foundation of Australia	Finalised.
Royal Australian College of General Practitioners	Finalised.
University of Newcastle	Finalised – Minister has granted approval for website.
University of Western Sydney	In progress.
Associate Professor David Fonda	In progress.
Flinders Consulting Pty Ltd	Finalised.
Australian Institute of Health & Welfare	Released.
GC Simsion, GR Bowles and Associates Pty Ltd	Released.
Vivienne Tippitt and Associated Pty Ltd	Released.
Practical PC Pty Ltd	Finalised.

Source: **Department of Health and Aged Care Annual Report 2000/2001, Appendix 12 "Consultancy Services"**

Outcome 3: Enhanced quality of life for older Australians

Consultant	Status of report
Access Economics	Released.
AgeInsite	Ongoing.
Alt Beatty Consulting	Released.
Bearcage Media Services	Consultancy completed.
Bentleys MRI (QLD) Pty Ltd in association with Bentleys MRI Perth Pty Ltd	Not released – commercial in confidence.
Booz Allan Hamilton	Completed.
Cultural Partners Australia NSW Pty Ltd	Released.
DMR Consulting	Internal report.
La Trobe	In progress.
Learning Curve Pty Ltd	Ongoing.
Quay Connections	Completed.
Queensland University of Technology	Finalised.
Simsion Bowles and Associates	Released.
The University of Newcastle	In progress.
University of NSW	In progress.
University of Southern Queensland	Report finalised and distributed to stakeholders.
University of Wollongong Centre for Health Service Development	In progress.
Wilton Hanford Hanover	Education under way.
Wilton Hanford Hanover	Released – 2 books.

Outcome 6: Hearing services

Consultant	Status of report
Simpson Norris International	Not released.
Vivienne Tippett and Associates Pty Ltd	Not released.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-143

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RESIDENT CLASSIFICATION SCALE

Written Question on Notice

Senator Evans asked:

(a) What has been the actual amount clawed back in 2001-02 from as a as a result of the 2001 Federal Budget decision to remove a nett $71m from residential care subsidies via additional Resident Classification Scale (RCS) checks by Department of Health and Ageing?
(b) Does the Government still intend to make such savings given the commitments to enhance residential care subsidies announced in the budget?

Answer:

(a) The Department recovered approximately $21.5 million from 1 July 2001 to 31 May 2002 through adjustments to misclassified RCS appraisals.

(b) The Department will continue to monitor RCS appraisals in order to make sure that all aged care providers receive their correct entitlement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-144

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: RESIDENTIAL AGED CARE ACCREDITATION

Written Question on Notice

Senator Chris Evans asked:

(a) How many residential aged care services does the Department believe can meet the proposed second round of residential care accreditation?
(b) What is the Department intending to do about services that are unable to afford to upgrade their facilities?
(c) What steps is the Government taking to ensure aged care homes can afford to upgrade their buildings to meet 2008 certification requirements?

Answer:

(a) All currently accredited residential aged care homes will have the opportunity to meet the outcomes in the second round of accreditation.

(b) Capital assistance is allocated through the annual Aged Care Approvals Round.

(c) See 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: E02-145

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: HOME AND COMMUNITY CARE PROGRAM

Written Question on Notice

Senator Evans asked:

Can the Government guarantee they will continue to contribute 60% (with the balance being provided by the States) of the funding for the Home and Community Care (HACC) program beyond the current agreement?

Answer:

HACC funding is considered by the Government each year in the Budget context.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-146

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: AGED CARE ASSESSMENTS

Written Question on Notice

Senator Evans asked:

How is the work of the Aged Care Assessment Teams monitored?

Answer:

Monitoring of Aged Care Assessment Teams is a State/Territory government responsibility. Information collected by Aged Care Assessment Teams, including the Minimum Data Set required by the Commonwealth, may be used to supplement local knowledge about issues and circumstances relating to the day to day administration of the Aged Care Assessment Program in each State/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: E02-147

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS
Topic: AGED CARE ASSESSMENTS

Written Question on Notice

Senator Evans asked:

(a) What is the average wait a person has before getting an assessment – can this be broken down by State and also location of the older person – ie: how many are waiting in their own home, hospital, a low care facility etc?
(b) How does the current wait for ACAT assessment compare to 1999, 2000?
(c) When will the reports undertaken by La Trobe University into the performance of ACATs be made available?
(d) Why have the last 3 not been released?

Answer:

(a-b) Waiting time between referral and assessment by an Aged Care Assessment Team (ACAT) is not data required to be collected as part of the current Minimum Data Set (MDS) for the Aged Care Assessment Program. Accordingly, the Department does not have comprehensive information on waiting lists..

(c-d) The Department of Health and Ageing has copies of the following National Minimum Data Set Reports on the Aged Care Assessment Program compiled by Lincoln Gerontology Centre, LaTrobe University:

July 1994 – June 1995
July 1995 – June 1996
July 1996 – June 1997
July 1997 – June 1998
July 1998 – June 1999
July 1999 – June 2000

The most recent of these reports is available on the Department's website.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-148

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: TOWNSVILLE NURSING HOME BEDS

Written Question on Notice

Senator Evans asked:

During the election Peter Lindsay MP from Townsville promised that 20 new nursing home beds would come on line in Townsville by December 2001. How many beds became operation between October 2001 and December 2001 in Townsville?

Answer:

A new residential aged care home is at the planning stage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-149

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: PORT DOUGLAS AGED CARE SERVICES

Written Question on Notice

Senator Evans asked:

During the election, Warren Entsh MP promised that there would be 20 new beds in Port Douglas and that money would be allocated for the redevelopment of Stella Maris Service in Port Douglas. Can the Department confirm that this has/will occur?

Answer:

The Roman Catholic Trust Corporation for the Diocese of Cairns proposes to utilise 20 places which have been non-operational since late 1999. In the 2001 Aged Care Approvals Round a capital grant of $660,000 was allocated to the Corporation to assist in building accommodation for an additional 20 high care residents at the Stella Maris Hostel.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-150

OUTCOME: WHOLE OF PORTFOLIO

Topic: ADVERTISING BY AGED & COMMUNITY CARE DIVISION

Written Question on Notice

Senator Evans asked:

(a) How much money did the Division of Aged and Community Care spend on all forms of advertising last financial year?
(b) What is the proposed advertising commitment for this year?

Answer:

(a) $1,249,644

(b) $419,122

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-151

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NON-AUSTRALIAN RESIDENTS ACCESS TO AGED CARE SERVICES

Written Question on Notice

Senator Evans asked:

(a) Is the Department aware of non-Australian residents receiving residential aged care subsides and using aged care services?
(b) What are the Department's guidelines on this?
(c) If the Department is aware of this how many non-Australian residents are using aged care services?

Answer:

(a) The Department holds no information concerning Australian residential status of people using aged care.

(b) Non-Australian residents are not precluded under the *Aged Care Act 1997* from receiving residential aged care subsidies or using aged care services provided they have a current assessment from an Aged Care Assessment Team (ACAT) indicating their need for such care.

(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: E02-152

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: TRANSITIONAL CARE ALLOWANCE

Written Question on Notice

Senator Evans asked:

How many individuals are currently in receipt of transitional care allowance?

Answer:

On 1 June 2002 there were 22,107 residents in aged care who were eligible for transitional supplement.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-224

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CONTINENCE AIDS ASSISTANCE SCHEME

Written Question on Notice

Senator Buckland asked:

(a) What demands will be met under the Continence Aids Scheme?
(b) What is proposed in order to meet the demands by those requiring the Continence Aids Scheme?

Answer:

(a) Each client will receive up to $465 worth of goods in 2002-03.

(b) PQ Lifestyles, who administer the scheme on behalf of the Commonwealth, provides a call centre which receives and processes orders from clients. PQ Lifestyles receives the funds, purchases goods from suppliers and delivers the goods free of charge.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-225

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CONTINENCE AIDS ASSISTANCE SCHEME

Written Question on Notice

Senator Buckland asked:

(a) Who qualifies for the Continence Aids Scheme?
(b) What is provided by the Continence Aids Scheme?
(c) How much funding is allocated to this scheme?

Answer:

(a) People who meet the eligibility criteria qualify for the Continence Aids Assistance Scheme. To be eligible the person must be:
- aged between 16 and 65; and
- have a permanent incontinence condition; and
- be eligible for the Disability Support Pension; or the Mobility Allowance.

A person who has reached the age of 65 and is in paid work for at least eight hours per week is eligible if they satisfy all other criteria.

(b) A subsidy up to $465 per person per year for the purchase of a range of continence management items.

(c) $10 million for the 2002-03 financial 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: E02-226

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CONTINENCE AIDS ASSISTANCE SCHEME

Written Question on Notice

Senator Buckland asked:

(a) How many people have applied for this scheme in the past?
(b) How long did it take to process applications for this scheme?
(c) What are the reasons for declining applicants?
(d) Who are the providers?
(e) How has this been allocated?
(f) How cost-effective is this process?

Answer:

(a) Since July 2001 over 1800 applications have been received.

(b) On the day of receipt of the application unless the application is complex in which case it is referred to Health Services Australia for assessment in consultation with the treating health professional.

(c) Applicants are not eligible if they do not meet the eligibility criteria.

(d) PQ Lifestyles Limited.

(e) A subsidy of $465 per client per year is allocated to PQ Lifestyles.

(f) It is very cost effective.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-227

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: NATIONAL CONTINENCE MANAGEMENT STRATEGY

Written Question on Notice

Senator Buckland asked:

(a) How will the National Continence Management Strategy's awareness be implemented?
(b) What will be involved?
(c) What will be the targeted group?
(d) How has this been ascertained?
(e) Who will benefit from this strategy?
(f) What will be the cost of implementing this strategy?

Answer:

(a) One of the main objectives of the National Continence Management Strategy (NCMS) is to increase community understanding and awareness of incontinence and to reduce the often attached stigma. This is being implemented through a range of public awareness and education initiatives.

(b) This will involve building on and expanding current projects and initiatives, such as:
- the National Continence Helpline;
- the National Toilet Map;
- the production and distribution of a wide range of information resources;
- health professional education;
- targeted media and publicity opportunities;
- public awareness and education projects under the Innovative Grants Program;
- the Commonwealth Continence Website; and
- the provision of support to the Continence Foundation of Australia (CFA).

(c) The targeted groups will include: new mothers, health professionals (including general practitioners, nurses and pharmacists), middle aged women, people from culturally and linguistically diverse backgrounds, Indigenous Australians, middle aged men and carers.

(d) This has been ascertained through advice from the National Continence Management Strategy Expert Advisory Committee and through results obtained from research initiatives, which indicate the above target groups are those most at risk of developing incontinence and those who are least likely to be aware of information on continence management.

(e) As well as the targeted groups, the strategy will be of benefit to all people with incontinence, their carers and the general community.

(f) The implementation of the public awareness and education initiatives under the NCMS will be approximately $3.8 million in 2002-03.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-228

OUTCOME 3: ENHANCED QUALITY OF LIFE FOR OLDER AUSTRALIANS

Topic: CONTINENCE AIDS ASSISTANCE SCHEME HELPLINE

Written Question on Notice

Senator Buckland asked:

(c) What is the helpline's purpose?
(d) What assistance will be provided by the helpline?
(e) What will be the hours of the helpline?
(f) Who will be providing the assistance on the helpline?
(g) What is the anticipated cost of this service?

Answer:

(a) To provide information on the Continence Aids Assistance Scheme (CAAS) to prospective applicants, carers, health professionals and to people with incontinence. PQ Lifestyles who administer CAAS for the Commonwealth, also provides a helpline at the cost of a local call.

(b) Assistance provided by the Department of Health and Ageing includes help with completing the application form, receiving and following up on complaints, referrals to other services such as the National Continence Helpline for professional advice on incontinence management. PQ Lifestyles' helpline provides the above services and also provides advice on products and takes queries and complaints about the provision of requested continence items.

(c) Department of Health and Ageing's helpline - 8.30 am to 5.30pm (EST) Monday to Friday. PQ Lifestyle's helpline - 8.30am to 5pm in each state.

(d) Officers of the Department of Health and Ageing. PQ Lifestyles call centre staff operate their helpline.

(e) Approximately $700 per year for the Department of Health and Ageing's helpline. Information is not available on the cost of PQ Lifetyles' helpline.

Commonwealth Department of
Health and Ageing

Health Services Division
GPO Box 9848, Canberra ACT 2601
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ABN 83 605 426 759

Mr Elton Humphrey
Secretary
Senate Community Affairs Legislation Committee
Parliament House
CANBERRA ACT 2600

Dear Mr Humphrey

Correction to Question on Notice E02000022 from Senate Additional Estimates Hearings 20 February 2002

I am writing to provide the Committee with a correction to questions (a), (b) and (c) of Question on Notice E02000022 of the Senate Community Affairs Legislation Committee's Additional Estimates 2001-2002 Hearings.

I have identified additional funding provided by the Department to Australian Divisions of General Practice (ADGP) which was inadvertently omitted from our original response.

A corrected E02000022 is attached.

Yours sincerely

[signed]

Andrew Stuart
First Assistant Secretary
Health Services Division
4 June 2002

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Additional Estimates 2001-2002, 20 February 2002

Question: E02000022
(amended)

OUTCOME 4: QUALITY HEALTH SERVICES

Topic: AUSTRALIAN DIVISIONS OF GENERAL PRACTICE

Hansard Page: Written

Senator Christopher Evans asked:

(a) Can you provide details of all funding provided by the department to Australian Divisions of General Practice (ADGP) in the last three years?
(b) What is the total funding each year?
(c) How is that broken up into funding for different projects?
(d) What was the basis of the special funding approved by the Minister for the Australian Divisions of GP's to assist in the implementation of the Governments budget initiatives? What benefits will the public see from this funding?

Answer:

(a) See Table in attachment.
(b) The total funding for each financial year is:
    - 1999/2000 – $3,085,996
    - 2000/2001 – $3,719,507
    - 2001/2002 – $4,661,958
(c) See Table in attachment.
(d) The $25.8 million announced by the former Minister for Health and Aged Care, Dr Michael Wooldridge, is allocated to 123 individual Divisions of General Practice (not the Australian Divisions of General Practice) over the period 2001-2002 to 2003-2004. The funding is for implementation of the budget initiatives relating to asthma, diabetes, mental health and practice nurses.

    The benefit to the public will be an integrated approach to chronic disease management in general practice that will assist in the prevention, diagnosis and management of chronic diseases.

CONTACT:	Leonie Smith (02) 6289 4302
CLEARED BY:	Andrew Stuart First Assistant Secretary Health Services Division (02) 6289 9310
DATE:	4 June 2002

Australian Divisions of General Practice (ADGP)

Description of the Services provided	Funding (inc GST)
1999/2000	
Develop evaluated models in key areas of GP/hospital collaboration through Division/hospital partnerships and disseminate the knowledge to the wider community	$12,000
Provision of national immunisation coordination services	$126,109
To develop effective roles for divisions of general practice in the accreditation support process, addressing identified target areas.	$250,000
ADGP core funding for ongoing operation 1999-2000	$1,415,000
Costs of participating in the GP Memorandum of Understanding	$540,000
Engagement of National Enhanced Primary Care coordinator under the GP Education, Support and Community Linkages (GPESCL) component associated with new MBS schedule items for enhanced primary care	$324,370
Project management of General Practice National Innovations Funding Pool – second round 1999/2000	$418,517
TOTAL – 1999/2000	*$3,085,996*
2000/2001	
Services for national primary mental health coordinator position within the Australian Divisions of General Practice	$379,720
Services for postgraduate primary care psychiatry scholarships for GPs – General Practice Branch component Mental Health & Special Programs Branch component	**$43,000** **$61,000**
ADGP core funding for ongoing operation 2000-2001	$2,059,462
Provision of national immunisation coordination services	$145,200
Management and coordination of the National Divisions Youth Alliance, which aims to enhance the capacity of GPs and Divisions to work in partnership with others to improve health outcomes for young people.	$825,000
Costs of participating in the GP Memorandum of Understanding	**$55,000**
Identification of a clear future role for Divisions of General Practice Information Management and Technology Support Officers	**$81,730**
The development of tender documents and supporting material for a National GP Leadership Skills Program and Division of General Practice Management Skills Program	**$69,395**
TOTAL – 2000/2001	*$3,719,507*
2001/2002	
Services in relation to coordinating the convening of a workshop for Primary Mental Health Care Development and Liaison Officers.	$9,320
ADGP core funding for ongoing operation 2001-2002	$2,043,500
Development and dissemination of familiarisation training required for General Practitioners (GPs) to deliver quality primary mental	$434,797

health care under the 'Better Outcomes in Mental Health Care' initiative.	
Provision of national immunisation coordination services	$158,400
Information Management Coordinator	**$248,077**
Arrangement of Information Management 'Think Tank'	**$19,178**
Redevelopment of ADGP website	**$229,370**
Project Management Services for Phase 2 of Integrated Care Project	**$333,059**
After Hours Primary Medical Care (AHPMC) National Coordinator and State/Territory policy officer positions	**$1,186,257**
TOTAL – 2001/2002	*$4,661,958*

NB: Contract values are noted in the year in which they were approved rather than being split across the years in which they will be paid. The table, therefore, includes approved amounts which will be spent in forward years.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-153

OUTCOME 4: QUALITY HEALTH CARE

Topic: GENERAL PRACTICE EDUCATION AND TRAINING

Written Question on Notice

Senator Evans asked:

$54.4 million has been budgeted for the establishment of consortia and delivery of training for the 15 months October 2001 to December 2002.

(a) How has this money been spent? Please provide details
(b) Was any of this money spent on consultancy fees? If so, please provide details.
(c) What funding will be allocated beyond December 2002?
(d) Please provide a list of the consortia with which GPET has contracts and their location.
(e) How many training places have been provided?
(f) Are these provided on an annual basis?
(g) Does this number include the 200 place rural training pathways to help ensure doctors are better equipped for rural and remote medical practice?
(h) How many of these rural places have been taken up?

Answer:

(a) The Department has provided to GPET via a Funding Agreement the amount of $54.4 million for the following purposes:

Administration funds	
$ 4,000,000	GPET administration and central functions
Trust Funds	
$ 1,500,000	ACRRM novated contract
$ 1,500,000	Establishment and set up of regional providers
$ 1,500,000	Development activities in regional areas in 2002
$ 2,500,000	National functions for registrar training and regional providers
$ 2,000,000	Innovations and projects
$ 8,000,000	Training of new registrars
$ 7,000,000	New consortia - training
$26,400,000	GPEA for pre 2002, Rural Training Stream and ‘gap’ registrars

(b) The Department did not spend any of the $54.4 million on consultancies. All money has been provided to GPET via the Funding Agreement.

(c) No funding to GPET for 2003 has been allocated to date. Negotiations will commence in the second half of 2002 regarding funding for the 2003 calendar year.

(d)

New South Wales		
Central West Consortium	-	Orange, Condobolin
Coast City Country GP Training	-	Wagga, Canberra, Illawarra
Valley to Coast	-	Newcastle
Institute of GP Education	-	Sydney
North Coast NSW GP Training	-	Coffs Harbour, Lismore
New England Area Training	-	Moree, Tamworth
Sydney Institute of GPET	-	Sydney
WentWest	-	Blue Mountains, Hawkesbury
Western NSW Regional Training	-	Dubbo, Coonabarabran, Broken Hill
Northern Territory		
Northern Territory GP Education	-	Northern Territory
Queensland		
Central and Southern Qld	-	Brisbane, Goldcoast, Ipswich, Toowoomba
Tropical Medical Training	-	Cairns, Townsville, Mackay
Rural and Regional Qld	-	Fraser Island, Rockhampton, Emerald
South Australia		
Adelaide to Outback	-	Adelaide, Clare, Yorke Peninsula
Sturt-Fleurieu	-	Barossa, Adelaide, Riverland, Murray-Mallee
Tasmania		
Tasmanian GPET	-	Tasmania
Victoria		
Bogong Regional Training	-	Albury, Wangaratta, Shepparton
Gippsland Education & Training	-	Foster, Moe, Sale, Lakes Entrance, Orbost
Greater Green Triangle	-	Sth West Victoria into Sth Australia
Victoria Felix	-	Ballarat, Bendigo, Bacchus Marsh, Sunbury
Victorian Metropolitan Alliance	-	Port Phillip Bay, Mornington & Bellarine Peninsulas
Western Australia		
Western Australian GPET	-	Western Australia

(e) 450 training places are made available.

(f) Yes.

(g) Yes.

(h) GPET has advised that 204 rural pathway registrars accepted places in the program for 2002, of whom 199 are currently engaged in the program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-230

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP HOUSE

Hansard Page: CA352

Senator Evans asked:

I meant in terms of your approval processes. Is this something that has to be signed off by the Minister or is there some sort of gazettal? As a representative of the Commonwealth, can you tell me who is responsible for that decision making process? Where does the buck stop?

Answer:

Any claim received from the Royal Australian College of General Practitioners (RACGP) will receive detailed senior-level scrutiny by the department and the approval process will then be reported upon in due course. Under Legal Services Directions, if the claim is in excess of $10,000, written advice will be required from an external legal adviser that payment of the claim is in accordance with legal principle and practice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-231

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP REGISTRARS

Hansard Page: CA353

Senator McLucas asked:

Could you get a list of where those Registrars are?

Answer:

Attached for your information is a list of registrars undertaking the Rural Training Pathway by State and RRMA Classification.

In summary, there are currently 199 registrars on the Rural Training Pathway of which, 133 are undertaking a hospital placement, 54 in Basic, Advanced or Subsequent GP training terms, 9 in a Special Skills placement and 3 on leave.

The majority of hospital placements are undertaken in large urban centre teaching hospitals (RRMA 1 – 3), as are Special Skills posts. The registrars undertaking their Basic, Advanced or Subsequent GP training terms are all located in RRMA 4 – 7.

Attachment E02-231

RURAL TRAINING PATHWAY NUMBERS BY STATE AND RRMA 2002

New South Wales					**Queensland**			
RRMA	1		43		RRMA	1		14
	2		4			2		3
	3		3			3		4
	4		9			4		2
	5		4			5		4
	6		-			6		2
	7		-			7		1
		Total	63				Total	30
Victoria					**South Australia**			
RRMA	1		22		RRMA	1		16
	2		3			2		-
	3		4			3		-
	4		14			4		5
	5		13			5		2
	6		-			6		-
	7		1			7		-
		Total	57				Total	23
Western Australia					**Northern Territory**			
RRMA	1		10		RRMA	1		2
	2		-			2		-
	3		-			3		-
	4		1			4		-
	5		1			5		-
	6		-			6		3
	7		-			7		2
		Total	12				Total	7
Tasmania								
RRMA	1		2					
	2		-					
	3		-					
	4		-					
	5		2					
	6		-					
	7		-					
		Total	4					

National Summary	
New South Wales	63
Victoria	57
Queensland	30
South Australia	23
Western Australia	12
Northern Territory	7
Tasmania	4
TOTAL	**196**
Registrars on leave	3
TOTAL REGISTRARS	199

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-157

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP REGIONAL TRAINING OUTER METROPOLITAN AREAS

Written Question on Notice

Senator Evans asked:

The aim of this program is stated to be 'to increase the supply of doctors working under-supplied outer metropolitan areas of the six State capital cities'.

One way this will be achieved is by providing GP registrars with training placements in Designated outer metropolitan areas.

It appears that this initiative will have the effect of taking GP registrars away from areas such as Newcastle and Gosford. However these areas have growing numbers of aged people and high doctor patient ratios.

(a) Has the Department considered the special needs of the Hunter and Central Coast in the development of this program?
(b) Is this region equivalent (on the basis of demographic and health needs data) to outer metropolitan Sydney?
(c) If not, why not?
(d) Can the Department guarantee that GP registrars will not be lost from this region to the designated outer metropolitan areas?

Answer:

(a) The Program targets the outer metropolitan areas of the six state capital cities of Australia. The Gosford and Wyong Statistical Local Areas of the Central Coast are part of the outer metropolitan area of Sydney and will be covered under the Program.

(b) The Gosford and Wyong Statistical Local Areas of the Central Coast are classified as outer metropolitan Sydney. The Newcastle/Hunter region is not.

(c) The Newcastle/Hunter region is classified as RRMA 2 metropolitan and is not eligible for inclusion on the More Doctors for Outer Metropolitan Areas Measure.

(d) The Program will not target GP Registrars to work in outer metropolitan Sydney from areas outside the Sydney Metropolitan area. Guidelines regarding the detailed operation of the Program are being developed in consultation with key stakeholders including the General Practice Registrars Association, General Practice Education Australia and Training Consortia.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-184

OUTCOME 4: QUALITY HEALTH CARE

Topic: RESEARCH INSTITUTE

Written Question on Notice

Senator Evans asked:

(a) Has the government agreed to fund a national Primary Health Care Research Institute at ANU? If so, how was this decision made?
(b) How much funding has been provided?
(c) What is the process for allocating these funds?

Answer:

(a) The Government decided to establish a National Institute of Primary Health Care Research in April 2000. It is one element of a broader strategy for primary health care research. The previous Minister for Health and Aged Care decided that the ANU would be funded to provide core coordination and research services to participating universities, researchers and also to government.

(b) A total allocation of $15 million is set aside for the Institute under the Primary Health Care Research Evaluation and Development Strategy over 5 years. $5 million of this will be for the core coordination and research services role of the ANU.

(c) The funds for the ANU coordination and research services role will be provided through a contract between the Commonwealth and the ANU with projects determined on the basis of a five-year research plan.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-158

OUTCOME 4: QUALITY HEALTH CARE

Topic: RURAL GPs

Written Question on Notice

Senator Evans asked:

(a) Please outline the total funds that have been spent on GP retention in rural and remote areas since 2000.
(b) Please provide the allocation of these funds to programs.
(c) Please provide the numbers of GPs in rural and remote areas over the same time frame.
(d) Please provide the measures by which the success of these programs is assessed.

Answer:

(a) $56.5 million

(b) Under the Rural Retention Program (RRP), $26.5 million has been spent since the beginning of the 2000/01 financial year.

Under the Rural and Remote General Practice Program (RRGPP), $30 million has been provided to Rural Workforce Agencies to recruit and retain GPs in rural areas since the beginning of the 2000/01 financial year.

(c) GPs in rural and remote areas:

	1999-2000	**2000-2001**	**%change**
Number or GPs	6210	6363	+2.5
Full-time Workload Equivalents	3636	3792	+4.3
Full-time Equivalents	3287	3417	+4.0

(d) The performance measure for the Rural Retention Program was to enable participation by over 1500 rural GPs under the Program (2000/01 Portfolio Budget Statements p.147).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-159

OUTCOME 4: QUALITY HEALTH CARE

Topic: GP REGIONAL TRAINING OUTER METROPOLITAN AREAS

Written Question on Notice

Senator Evans asked:

Dr Wooldridge signed agreement last October 8 approving $5.6 million to go to the Australian College of Rural and Remote Medicine. In February this agreement was still being negotiated.

(a) Has this contract now been signed?
(b) If so, when? If not, why not?
(c) Is this contract for the development phase, the implementation phase, or both?

Answer:

(a) No.

(b) Discussions are continuing with the Australian College of Rural and Remote Medicine (ACRRM) on the development and implementation of the proposal.

(c) It is envisaged that the contract will cover both the developmental and implementation phases. Funding for implementation will be contingent on the achievement of agreed outcomes for the developmental 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: E02-160

OUTCOME 4: QUALITY HEALTH CARE

Topic: ALLIED HEALTH CARE PROFESSIONALS IN RURAL COMMUNITIES

Written Question on Notice

Senator Evans asked:

Previous budgets have allocated $10.5 million in 2000-2001 and $11.4 million in 2001-2002 for more allied health services in regional and rural communities. This was described as enabling these communities to access allied health services not previously available in some areas, including practice nurses, psychologists, physiotherapists and podiatrists.

How has this money been spent? Please provide this information by state and by health professional category.

Answer:

Some 164 full time equivalent positions were being funded under the More Allied Health Services (MAHS) Program nationally, as at 2 April 2002. Attachment A identifies the range of allied health professions funded under the MAHS Program and their distribution by state/territory at that date.

Attachment A

Health Professional Type	Full-Time Equivalent Positions							
	NSW	**NT**	**QLD**	**SA**	**Tas**	**Vic**	**WA**	**Nat.**
Psychologists	10.5	0.6	5.9	1.8	3.0	7.9	2.2	**31.8**
Registered Nurses - Diabetes Educator	2.2		3.9	3.5	2.1	4.6	1.5	**17.7**
Registered Nurses - Mental Health	0.5		0.8	3.6			0.4	**5.3**
Registered Nurses - Asthma Educator	1.2			2.4		0.5	0.5	**4.6**
Registered Nurses - Other	10.6		1.9	4.3		0.7	1.1	**18.5**
Dietitians	4.6		6.0	0.2	0.6	2.0	3.8	**17.1**
Counsellors	2.8		0.2	2.5		1.1	5.9	**12.5**
Social Workers	1.0		3.9	0.4		3.6	1.4	**10.3**
Podiatrists	2.7	0.5	2.7	0.6	0.5	1.2	1.7	**9.9**
Physiotherapists	2.1	0.5	2.3	0.2		2.8	1.1	**8.9**
Aboriginal Mental Health Workers		6.0						**6.0**
Mental Health Worker	1.0			2.0		2.0		**5.0**
Occupational Therapists	1.8		2.1		0.5	0.1		**4.5**
Speech Pathologists	1.2		0.7			0.4		**2.3**
Aboriginal Health Workers			1.0	0.2		0.2	0.8	**2.2**
Audiologists		0.2				0.1	0.3	**0.6**
Other	2.0		1.0	0.2		3.6	0.4	**7.2**
Total	**44.1**	**7.8**	**32.2**	**21.8**	**6.7**	**30.6**	**21.1**	**164.3**

NB FTE totals may not add up due to rounding of figures.

MSOAP PROJECTS APPROVED FOR FUNDING AS AT JUNE 2002

The delivery of the planned services will depend on the availability of specialists.

New South Wales – total $4,376,750 (9 rural regions)

- **Far West region –** up to $520,000 over three years 2001-02 to 2003 -04
  general physician at Walgett and surrounding towns; general physician at Menindee; dermatologist at Broken Hill; Neurologist at Broken Hill; endocrinology to Bourke, Brewarrina, Goodooga, Lightning Ridge, Collarenabri, Walgett, Wilcannia, Menindee, Ivanhoe, Balranald and Dareton.
- **Mid North Coast region –** up to $1,340,750 over three years 2001-02 to 2003-04
  dermatology and rheumatology clinics in Coffs Harbour; anaesthetic upskilling for GPs at Kempsey Hospital; endocrinology services at Port Macquarie; advanced specialist training post in dermatology to do rotations through Coffs Harbour, Lismore and Port Macquarie; endocrinologist, psychogeriatrician, respiratory physician and neurologist at Kempsey; palliative care physician at Taree; psychogeriatrics at Coffs Harbour, Macksville, Bellingen and Dorrigo; psychiatry at Bellingen; neuropsychiatry at Port Macquarie and Coffs Harbour; child and adolescent psychiatry at Kempsey, Crescent Head, South West Rocks and Bellbrook.
- **Macquarie region –** up to $681,000 over three years 2001-02 to 2003 -04
  upskilling of local general surgeons in colo-rectal techniques at the Dubbo Base Hospital; psychiatric registrar service, cardiologist, neurologist and expansion of respiratory medicine services in Dubbo; palliative care physician and the expansion of rheumatology services in the region; rehabilitation services, expansion of psychogeriatric services, and the expansion of geriatric services at the Lourdes Hospital; in Dubbo.
- **Hunter region –** up to $185,000 over three years 2001-02 to 2003-04
  paediatric endocrinology services, paediatric neurology services and paediatric surgery in Muswellbook ; psychiatry to Scone & Muswellbrook; psychiatry to Singleton; ear, nose and throat specialist to Nelson Bay; general physician to Nelson Bay.
- **Northern Rivers region** – up to $259,000 over three years 2001-02 to 2003-04
  Psychogeriatrician at Ballina and Lismore; child and adolescent psychiatry services at Lismore; neurosciences services at Lismore; expansion of clinical genetic services at Lismore, Tweed Heads and Grafton
- **Mid Western region** – up to $187,000 over three years 2001-02 to 2003-04
  extension of oncology services at Cowra and Lithgow; ear, nose and throat service at Orange; extension of the provision of upskilling to rural GPs and nursing staff in the region; renal vascular service in Orange
- **Greater Murray region -** up to $1,215,000 over three years 2001-02 to 2003-04
  anaesthetist to Corowa; neurologist to Griffith; urologist, orthopaedic surgeon, gynaecologist and oncologist to Deniliquin; paediatric haematology to Wagga Wagga; paediatrician to Wagga and Griffith; paediatrician to Corowa, Holbrook and Culcairn; orthopaedic surgery, geneticist, psychiatrist to Griffith; psychiatry, dermatology to Deniliquin; psychiatry to Albury, Wagga and Tumut.
- **Southern region -** up to $180,000 over three years 2001-02 to 2003-04
  radiation oncology and haematology services to Young; geriatric rehabilitation and palliative care to Eurobodalla, Bega, Young; radiation oncologist and haematologist to Moruya, Bega and Goulburn; paediatric ear nose and throat specialist to Narooma
- **Lower Illawarra region –** no services identified to date.

Victoria – total $5,241,000 (5 rural regions)

- **Loddon-Mallee region -** up to $1,291,000 over three years 2001-02 to 2003-04

cardiology, advanced endoscopy, endocrinology, general medicine, geriatric medicine, neurology, obstetrics/gynaecology, oncology, orthopaedics, paediatric medicine and psychiatry in the Mildura/Robinvale area; cardiology, dermatology, endocrinology, ENT, general medicine, general surgery, neurology, obstetrics/gynaecology, oncology, opthalmology, orthopaedics, paediatric medicine, psychiatry, respiratory and urology in the Swan Hill/Buloke North/Gannawarra area.

- **Barwon South Western region -** up to $1,000,000 over three years 2001-02 to 2003-04.
  General medicine, general surgery, geriatrics/rehabilitation, paediatrics, psychiatry, dermatology, ear, nose and throat services, neurology and oncology in the Far South West catchment area; adolescent psychiatry, dermatology, and neurology in the Warrnambool/ Port Fairy area of the Central South West catchment area; geriatrics/rehabilitation, gynaecology, psychiatry, dermatology, neurology, drug and alcohol services, opthalmology and orthopaedics in the Camperdown/Cobden/Terang/Timboon area of the Central South West catchment area; general medicine, paediatrics, psychiatry, and opthalmology in the Colac-Otway South catchment area.
- **Gippsland region** - up to $1,260,000 over the three years 2001-02 to 2003-04.
  Psychiatry, rheumatology, geriatric and psycho-geriatric services, ear,nose and throat services, ophthalmology, dermatology, neurology, paediatrician, surgery and renal physician in locations including Mallacoota, Orbost, Omeo, Lakes Entrance, Bairnsdale, Woolartbe, Sale, Yarram, Foster and Wonthaggi.
- **Grampians region –** up to $790,000 over three years 2001-02 to 2003-04
  Ear, nose and throat services, general medicine, gastroenterology, geriatrics/psychogeriatrics, neurology, oncology, paediatrics, paediatric neurology, paediatric cardiology, paediatric endocrinology, plastic surgery, psychiatry, renal medicine, respiratory medicine, rheumatology, vascular surgery, and Aboriginal community controlled health services at Horsham in the Wimmera catchment area; ear, nose and throat services, general medicine, general surgery, geriatrics, obstetrics and gynaecology, oncology, ophthalmology, orthopaedics, paediatrics and psychiatry at Hindmarsh, West Wimmera and Yarriambiack;
  Dermatology, endocrinology, general medicine, geriatrics, oncology, paediatrics and psychiatry in Ararat and Stawell; and general medicine, general surgery, obstetrics and gynaecology, ophthalmology, orthopaedics and psychiatry in St Arnaud and Buloke, in the Grampians Catchment Area.
- **Hume region** – up to $700,000 over two years 2002-03 to 2003-04
  General medicine, general surgery, obstetrics and gynaecology, opthalmology. orthopaedics, geriatrics, paediatrics; psychiatry, dermatology, urology, endoscopy, infectious diseases and ear, nose and throat services.
- **Six advanced specialist training posts** in rural areas including internal medicine at Sale, paediatrics at Wodonga, renal medicine at Barwon Health, and child and adolescent psychiatry at Bendigo – funding of $900,000 for the two calendar years 2001 and 2002.

Queensland – total $4,829,874 (20 rural regions) * due to the geographical distribution of the population in Queensland the services have been developed as "milk runs" – that is, they are servicing across a number of regions

- Obstetrics and gynaecology at Mt Isa – up to $487,500 over the three years 2001-02 to 2003-04.
- Outreach paediatrics services from Roma and Mt Isa – up to $1,135.780 over the three years 2001-02 to 2003-04.
- Paediatrics support and education services for rural medical practitioners at 11 rural sites - up to $375,000 over the three years 2001-02 to 2003-04.

- Renal outreach services to the Cairns and Cape regions - up to .$150,000 over the three years 2001-02 to 2003-04
- Diabetes/endocrinology outreach services to the Cairns, Cape and Mt Isa regions – up to $245,000 over the three years 2001-02 to 2003-04.
- Dermatology, cardiology and opthalmology to the Mt Isa region (includes Mt Isa, Cloncurry, Doomadgee, Normanton, Mornington Island, Julia Creek, Dajarraa, Burketown, Camooweal) – up to $320,407 over the three years 2001-02 to 2003-04.
- Dermatology, opthalmology, physician and ear, nose and throat services to the Charters Towers region (includes Charters Towers, Richmond, Hughenden) – up to $345,998 over the three years 2001-02 to 2003-04.
- Opthalmology and orthopaedics the Tablelands region (includes Atherton, Mareeba) – up to $96,632 over the three years 2001-02 to 2003-04.
- Opthalmology, physician, cardiology, dermatology, and ear, nose and throat services to the Moranbah region (includes Emerald, Moranbah, Clermont) – up to $287,199 over the three years 2001-02 to 2003-04.
- Opthalmology services to Gayndah and Cunnumulla – up to $82,425 over the three years 2001-02 to 2003-04.
- Orthopaedics, general physician, cardiology, renal physician, gastroenterology, neurology, medical oncology, and ear, nose and throat services to Bundaberg - $320,042
- Respiratory physician, gastroenterology, cardiology, neurology, orthopaedic, and ear, nose and throat services to Gladstone – up to $390,818
- General physician, respiratory physician, orthopaedics, neurosurgery, ophthalmology, obstetrics and gynaecology services to the Rockhampton region - $248,720
- Dermatology outreach services to Thursday Island, Gayndah, Kingaroy, Roma, Cunnumulla, Charleville, Goondiwindi , Longreach, Blackall ($344,353)

South Australia – total $3,053 ,000 (7 rural regions)

- **Statewide -** Visiting psychiatry services in rural areas – up to $1,250,000 over the four years 2000-01 to 2003-04; Palliative care services and support for rural health practitioners – up to $150,000 over the three years 2001-02 to 2003-04; It is proposed that the Rural Doctors Workforce Agency facilitate upskilling for General Practitioners practicing in rural and remote areas of South Australia in the specialities of anaesthetics, obstetrics and paediatrics.($305,000)
- **Hills Mallee Southern region** - Paediatric and geriatric services to Kingscote; Dermatology and general physician services to Lameroo and Meningie - proposed funding up to $51,000 over the three years 2001-02 to 2003-04
- **Mid North region** - Dermatology services to Booleroo Creek, Crystal Brook and Port Pirie; Physician services to Port Pirie and Crystal Brook; Endocrinologist services to Port Pirie and Crystal Brook - proposed funding up to $42,000 over the three years 2001-02 to 2003-04
- **Riverland region -** General physician services to Renmark, Berri and Loxton; Dermatology services to Renmark, Berri and Waikerie; Gastroenterologist services to Barmera and Berri
- **South East region** - General physician services to Mount Gambier, Beachport and Millicent; Paediatric services to Beachport and Millicent; Neurology services to Naracoorte; Orthopaedics services to Kingston, Robe and Keith - proposed funding up to $140,000 over the three years 2001-02 to 2003-04
- **Wakefield region** - Dermatology services to Moonta, Minlaton, Maitland and Yorketown; Paediatric services to Wallaroo; Plastic surgery services to Ardrossan, Maitland and Wallaroo; Neurology services to Kadina, Wallaroo and Moonta; Gastroenterology services to Yorketown;

Cardiology services to Maitland; Geriatric services to Riverton, Auburn and Saddleworth - proposed funding up to $190,000 over the three years 2001-02 to 2003-04

- **Eyre region** - Ear, nose and throat services to Kimba, Cleve and Cowell; Paediatric services to Port Lincoln; Geriatric services to Tumby Bay, Cummins, Wudinna, Streaky Bay and Elliston; Ophthalmology services to Ceduna, Yalata and Oak Valley; Orthopaedic services to Port Lincoln - proposed funding up to $265,000 over the three years 2001-02 to 2003-04
- **Northern and Far West region** - Ear, nose and throat services to Coober Pedy and Oodnadatta; Obstetric and gynaecology services to Leigh Creek, Port Augusta and Roxby Downs; Dermatology services to Roxby Downs and Coober Pedy; Paediatric services to Leigh Creek, Coober Pedy, Roxby Downs, Copley, Iga Warta, and to the Pitjantjatjara communities; Ophthalmology services to Roxby Downs, Maree, Oodnadatta and to the Pitjantjatjara communities; Gastroenterology services to Coober Pedy; Physician services to the Pitjantjatjara communities - proposed funding up to $540,000 over the three years 2001-02 to 2003-04

Western Australia – total $3,376,317 (6 rural regions)

- **Goldfields region -** General physician services, paediatric services, obstetrics and gynaecology, and ear, nose and throat services – up to $423,106 over the three years
- **Midlands region -** Dermatology, ophthalmology, rheumatology, psychiatry, general physician services, orthopaedics, geriatric services, and ear, nose and throat services - up to $193,196 over the three years 2001-02 to 2003-04.
- **Great Southern -** Gynaecology, dermatology, orthopaedic surgery, ophthalmology, oncology and ear, nose and throat services - up to $163,140 over the three years 2001-02 to 2003-04.
- **Midwest -** Dermatology, psychiatry, general physician services, paediatric services and paediatric ear, nose and throat services - up to $193,880 over the three years 2001-02 to 2003-04.
- **North West -** Paediatric, gynaecology, surgery, orthopaedic, general medicine, cardiology, echo-cardiology, psychiatry, ophthalmology, dermatology, genetics, urology, nephrology, palliative care, and ear, nose and throat services – up to $800,000 over the three years 2001-02 to 2003-04.
- **South West -** Ear, nose and throat services – up to $10,000 over the three years 2001-02 to 2003-04.
- **Statewide -** Specialist outreach services and training in obstetrics and gynaecology in eighteen major rural centres – up to $209,533 over the three years 2001-02 to 2003-04; Specialist outreach services and training in anaesthetics and pain management in eighteen major rural centres up to $283,462 over the three years 2001-02 to 2003-04.
- **Total funding to WA Health Department (for statewide services) –**Funding of up to $1,100,000 over the three years 2001-02 to 2003-04 has been approved for the Western Australian Department of Health for additional services in the following specialities will be provided by in a large number of rural towns. Services include surgery, pain management, ophthalmology, dermatology, physician, rheumatology, psychiatry, geriatric, orthopaedic, diabetic, endocrinology, gynaecology, paediatric, plastic surgery, pain clinic, spine clinic, urology, psycho-geriatric, oncology, and ear, nose and throat services. The funding also includes support for an advanced training post in paediatrics in the Kimberley region.

Tasmania – total $1,326,460 (3 rural regions)

- **North and North West -** Forensic psychiatry services in north and north west Tasmania – up to $279,130 over the four years 2000-01 to 2003-04.
- **Statewide (to North, North West and South) -** Palliative care services – up to $534,941 over the four years 2000-01 to 2003-04; General psychiatry services in rural areas – up to $612,330 over the three years 2000-01 to 2003-04; Rheumatology, dermatology and urology services in rural areas – up to $435,000 over the three years 2000-01 to 2003-04

Rheumatology services to Burnie/Somerset, Devonport, Smithton in north west Tasmania, to Deloraine/Westbury in north Tasmania, and to Nubeena, Ouse and Huonville/Cygnet in south Tasmania
Dermatology services to Burnie, Devonport, Smithton and Ulverstone in north west Tasmania, to Deloraine/Westbury, George Town and Scottsdale in north Tasmania, and to Huonville/Cygnet in south Tasmania
Urology services to St Helens in north Tasmania

Northern Territory – total $1,600,000 (2 rural regions)

- **Central Australia and Barkly regions -** Community physician and obstetrics and gynaecology services – up to $1.6 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: E02-154

OUTCOME 5: RURAL HEALTH CARE

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM

Written Question on Notice

Senator Evans asked:

Initially $14.3 million was allocated for the Medical Specialist Outreach Assistance Program. There was an attempt to allocate some of this money ($4 million) to the infamous GP house.

(a) What caused the delays in consultation and negotiation that made this $4 million available for the GP House program?
(b) What is the current status of these consultations and negotiations?
(c) Have these funds now been spent as originally intended?
(d) How was the remainder of this funding spent?
(e) If it was not all spent, why not?
(f) What was the basis for the initial allocation of funds in this area?
(g) Who made the decisions that this area should be funded to the order of $14.3 million?

Answer:

(a) Delays were due to early difficulties in finalising arrangements with some state governments; establishing consultative and advisory structures; finalising service plans in some communities and the recruitment of specialists to deliver the services.

(b) Program guidelines have been agreed with state governments; advisory structures are now in place; most service plans have been finalised; and a small proportion of services are realising difficulties in recruiting specialists.

(c) The remaining funds available for this financial year have been spent as originally intended.

(d) The $4 million is to be spent in 2002-2003 in support of a range of projects provided through specialist medical colleges to support existing rural specialists. This is a new element of the Medical Specialist Outreach Assistance Program and will complement existing Program activities. (Portfolio Budget Statements 2002-03, Budget measures affecting Outcome 5, p. 141).

(e) See (a & d) above.

(f) This was part of the Regional Health Strategy initiative announced by the Government in the 2000-01 Budget.

(g) See (f)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-232

OUTCOME 5: RURAL HEALTH CARE

Topic: MEDICAL SPECIALIST OUTREACH ASSISTANCE PROGRAM

Hansard Page: CA 192

Senator Denman asked:

How many patients do you expect to benefit from dermatology and rheumatology services under the Medical Specialist Outreach Assistance Program in Tasmania?

Answer:

Funding has been approved for a rheumatologist to visit Tasmanian rural centres for 34.5 days per year, and for a dermatologist to visit rural centres for 34 days per year. The number of patients seen will depend on the length of consultations.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-238

OUTCOME 5: RURAL HEALTH CARE

Topic: RURAL HEALTH SUPPORT, EDUCATION AND TRAINING GRANTS PROGRAM

Hansard Page: CA 196

Senator McLucas asked:

Could we get a list of the 23 successful Rural Health Support, Education and Training (RHSET) Grants Program applications?

Answer:

Projects Funded Under the Rural Health Support, Education and Training (RHSET) Program in 2001-02 are described below.

TASMANIA

Building the Primary Health Care Capacity of Community Groups and Services in Rural Tasmania. (University of Tasmania - $65,000)

NEW SOUTH WALES

Getting it Together. Training and support for health workers and Aboriginal communities. (Yoorana Gunya Family Violence Healing Centre - $14,165)

Overcoming isolation through knowledge and support networks. (Centre for Family Health and Midwifery - $70,000)

Peer review, clinical supervision and professional education package to support the practice of isolated Women's Health Nurses in Far West New South Wales. (FPA Health – $53,373)

A metropolitan rural-remote partnership supporting and management and prevention of diabetes and cardiovascular disease in the Far West of New South Wales. (Prince of Wales Hospital - $69,250)

Training of rural health workers in the management of adjuvant and systemic chemotherapy for colorectal cancer. (Medical Oncology Group of Aust - $70,000)

Recognising wisdom: anxiety, depression and CVD in rural, isolated older men. (Wodonga Regional Health Service - $69,387)

Enhancement of Remote Area Practice. Education workshops. (University of Sydney - $150,000)

QUEENSLAND

Triple P goes bush: supporting families in rural communities. (University of Queensland - $69,995)

Work Psychology in Rural Health Settings. (James Cook University - $61,415)

A collective approach in capacity building and network development for health workers and local men to address community health issues. (Apunipima Cape York Health Council - $70,116)

Supporting Community control of head lice in rural primary schools in North Queensland. (James Cook University - $69,965)

WESTERN AUSTRALIA

Perinatal care for illicit-drug-using mothers and their infants. (Curtin University of Technology - $69,962)

Gascoyne Healthy Lifestyle Program. (Kuwinyuwardu Aboriginal Resource Unit (KARU) - $70,000)

Care & Co. Counselling and support for health workers. (University of Western Australia - $58,500)

South West Clinical Placement Program. A supported Emergency Nursing Clinical Placement Program. (Bunbury Health Service - $70,000)

The ages and stages of play and learning (0-5 years) family education videos for Aboriginal communities. (State Child Development Centre - $69,303)

Carnarvon, Sea Change. Addressing staff morale in rural workforce. (Gascoyne Health Service - $63,900)

Video-otoscopy and tele-otology training for rural and remote area health workers. (Lions Ear and Hearing Institute - $69,619)

SOUTH AUSTRALIA

Extending the clinical education and experiences of Aboriginal Health Workers for the Improvement of Aboriginal Health. University of South Australia - $61,790)

Managing challenging behaviour in older adults: online training for staff in rural communities. (Centre for Aging Studies - $68,020)

NORTHERN TERRITORY

Mentor and clinical supervision program for inexperienced remote practitioners. (Centre for Remote Health - $70,000)

Management of the pregnant women and related emergencies for remote health practitioners. (Council of Remote Area Nurses of Australia Inc. - $70,000)

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-235

OUTCOME 5: RURAL HEALTH CARE

Topic: OUTCOME 5 PROGRAMS AND BUDGET ALLOCATION

Hansard Page: CA 197-8

Senator McLucas asked:

Could we get a list of all the programs under Outcome 5 and the disaggregated budgets for each individual program in Outcome 5?

Answer:

A list of all programs under Outcome 5 and the disaggregated estimated budgets for each individual program for the 2001-02 financial year are below.:

Administered Item 1. Support education and training for health workers	
University Departments of Rural Health	$14,472,000
Medical Specialist Outreach Services Program	$8,331,000
Royal Flying Doctor Service	$21,329,000
Advanced Specialist Training Posts	$2,000,000
Specialist Workforce Support	$500,000
Rural Nursing Initiative - Undergraduate	$1,900,000
Rural Practice Nursing - Re-entry	$1,250,000
National Rural and Remote Health Support Services Program (Details of this Program in Q 234)	$7,443,000
Total allocated cost for Administered Item 1:	**$57,225,000**

Administered Item 2. Health Services for rural communities	
Regional Health Services	$25,118,000
Multipurpose Centres	$1,708,000
Total cost for Administered Item 2:	*$26,826,000*
Total allocated cost for both Administered items for 2001-02	***$84,051,000***

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-234

OUTCOME 5: RURAL HEALTH CARE

Topic: NATIONAL RURAL AND REMOTE HEALTH SUPPORT SERVICES PROGRAM

Hansard Page: CA197

Senator West asked:

Could we get a total funding figure for the National Rural and Remote Health Support Services Program with a breakdown for each individual program?

Answer:

The disaggregated budgets for the major components of this program are listed below.

National Rural and Remote Health Support Services Program	
Support for Rural Health Organisations	$1,724,752
Additional Activity/Infrastructure support for UDRH	$1,160,000
Upskilling/Scholarships	$2,229,172
Education/Training of rural health workers	$914,474
Rural Health, Support Education and Training Program	$1,414,602
Total allocated cost for this Program for 2001-02	**$7,443,000**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-237

OUTCOME 5: RURAL HEALTH CARE

Topic: REGIONAL HEALTH SERVICES AND MULTIPURPOSE SERVICES

Hansard Page: CA 200

Senator West asked:

Could we get a list of all the planned and operational Regional Health Services by State and Territory? Could you include Multipurpose Services in this list and indicate which services receive both MPS and RHSP funding.

Answer:

Attached is a list of all planned, operational and completed Regional Health Services and Multipurpose Services by State and Territory.

Regional Health Services funding is available for planning, establishment and delivery of new primary health care services. As such, funded services/projects can be characterised as:

Planning projects: where funding is provided to assist communities to determine their health needs and to produce a service plan which will form the basis of a subsequent health service delivery proposal. Planning can include things such as needs assessment and community consultation;

Service delivery projects: where funding is directed towards projects for the provision of new or enhanced primary health care services to communities of 5000 or less;

Not yet operational: are projects, including both service delivery and planning projects, which have been approved by the Minister and are in the contract negotiation stage;

Not yet operational Multipurpose Services are planned Multipurpose Services that have received approval to proceed from both Commonwealth and State Governments.

Complete: projects with a service plan, needs assessment and/or a community consultation report which have been completed and provided to the Department.

Question on Notice – list of Regional Health Services and Multipurpose Services	
New South Wales	
Regional Health Services **Planning** Berrigan & Jerilderie (completed) Bland Shire (completed) Cobar (not yet operational) Coleambally (completed) Condobolin (completed) Eden Monaro (completed) Eurobodalla Greater Murray (completed) Henty (completed) Junee Shire Mid North Coast (completed) Mid West Murrundi Shire New England North East New England Northern Rivers Northern Rivers Western Cluster (completed) Riverina Murray Shoalhaven Tottenham & Tullamore Werris Creek (completed) **Service Delivery Projects** Bega and Eden Outreach RHS Berrigan & Jerilderie Shires RHS (not yet operational) Cooma Monaro Shire RHS (not yet operational) Eden RHS Engonnia & Weilmoringle RHS Gunning RHS Lower Western Sector East RHS Macquarie RHS Mid North Coast Chronic Disease RHS Mid Western RHS (not yet operational Mulwaree Shire RHS (not yet operational) Northern Rivers RHS Nundle project RHS (not yet operational) Riverina Low Vision RHS Shoalhaven Indigenous Carers Training RHS (not yet operational) Shoalhaven Small Communities Health RHS Study (not yet operational) Southern Regional Youth Outreach RHS (not yet operational) Walgett RHS Wreck Bay Project RHS (not yet operational)	**Multipurpose Services** Baradine MPS Boggabri MPS (not yet operational) Braidwood MPS Collarenebri MPS (not yet operational) Coolah MPS (not yet operational) Coolamon MPS Culcairn MPS Delegate MPS Dorrigo MPS Dunedoo MPS(not yet operational) Emmaville MPS (not yet operational) Gilgandra MPS (not yet operational) Grenfell MPS Jerilderie MPS Lake Cargelligo MPS Lord Howe Island MPS (not yet operational) Oberon MPS Trangie MPS Trundle MPS Tumbarumba MPS Urana MPS Urbenville MPS Warren MPS

Victoria	
Regional Health Services **Planning** Alpine Health Edenhope (completed) Foster (completed) Nyah San Remo (completed) **Service Delivery** Apollo Bay RHS Ararat Youth Leadership RHS (not yet operational) Beaufort / Skipton RHS Central Highlands RHS Chiltern RHS Cobden RHS Corryong / Walwa RHS East Grampians RHS East Wimmera RHS (not yet operational) Glenview RHS Hepburn RHS Mallacoota and Cann River RHS (not yet operational) Maryborough RHS Northern Grampians RHS (not yet operational) Omeo RHS Orbost RHS Portland / Warrnambool RHS Ramahyuck District Aboriginal Co-operative RHS Project (not yet operational) Robinvale RHS South Loddon RHS (not yet operational) Violet Town RHS Wimmera Hearing RHS Yarriambiack RHS	**Multipurpose Services** Alpine Health MPS* Apollo Bay MPS * Corryong MPS* Mallee Track MPS Orbost MPS* Robinvale MPS* Timboon MPS *Auspices of these MPS also receive RHS funding

Queensland	
Regional Health Services <u>Planning</u> Agnes Water (completed) Bauhinia Shire (completed) Central West Clermont (completed) Gulf Savannah Killarney (completed) Maranoa North West Qld (completed) Pittsworth (completed) Qld Busing Nursing Association (completed RHS Service Capacity Building Project South Qld (completed) Taroom / Wandoan (completed) Theodore (completed) Woorabinda (completed) **Service Delivery** Bauhinia Shire RHS Burdekin RHS Charleville RHS Clermont RHS Collinsville RHS Cooktown RHS Discovery Coast RHS Douglas Shire RHS North West Qld RHS Paroo & Bulloo Shires RHS QLd Bush Nursing Association RHS Qld RHS and MPC forum project (not yet operational) RFDS Clinical Mental Health RHS RFDS Mental Health Literacy RHS Tamboo Shire RHS Theodore RHS Western Qld RHS	**Multipurpose Services** Barcaldine MPS (not yet operational) Bauhinia MPS* Blackall MPS (not yet operational) Clermont MPS* Dirranbandi MPS Cooktown MPS* Douglas Shire MPS* Inglewood MPS Jericho Shire MPS Mundubbera MPS Quilpie MPS Texas MPS Theodore MPS* Woorabinda MPS * Auspices of these MPS also receive RHS funding

South Australia	
Regional Health Services **Planning** Burra Clare Snowtown (competed) Coober Pedy (completed) Eastern Eyre (completed) Mid North Murray Mallee (completed) Northern and Far West Southern and Central Yorke Peninsula (completed) **Service Delivery** Burra Clare Snowtown RHS Coober Pedy RHS (not yet operational) Eastern Eyre RHS Lower Eyre RHS Mallee RHS Meningie RHS Mid West RHS Southern and Central Yorke Peninsula (not yet operational)	**Multipurpose Services** Ceduna / Yalata MPS Coober Pedy* (not yet operational) Eastern Eyre MPS* Kangaroo Island MPS Mallee MPS* (not yet operational) Mid West MPS* Nganampa MPS * Auspices of these MPS also receive RHS funding

Western Australia	
Regional Health Services **Planning** Central Great Southern Central Wheatbelt (completed) Fitzroy Crossing (not operational) Kimberley North Midlands **Service Delivery** Central Wheatbelt GPD Mental Health RHS Eastern Wheatbelt RHS Gascoyne RHS Great Southern RHS Kimberley Aged Care RHS Kimberley Counselling RHS Kimberley Nurse Training RHS Mid West RHS Murchison RHS Ngaanyatjarra RHS North Midlands RHS South East Coast RHS Walpole RHS Wiluna Health Promotion and Education RHS (not yet operational) Wundowie / Toodyay RHS (not yet operational)	**Multipurpose Services** Augusta MPS Beverley MPS Boyup Brook MPS Bruce Rock MPS (not yet operational) Central Great Southern MPS* Corrigan MPS (not yet operational) Cunderdin MPS Dalwallinu MPS Denmark MSP Dongara Mingenew Eneabba MPS Dumbleyung MPS (not yet operaitonal) Eastern Wheatbelt MPS* Goomalling MPS (not yet operational) Kondinin / Kulin MPS Lake Grace MPS Leonora Laverton MPS Moora MPS Morawa Perenjori MPS (not yet operational) Mullewa MPS (not yet operational) Murchison MPS* Nannup MPS (not yet operational) Norseman MPS Northampton Kalbarri MPS Northern Midlands MPS Pemberton MPS Quairanding MPS (not yet operational) Ravensthorpe MPS Wongan Hills MPS York MPS * Auspices of these MPS also receive RHS funding

Northern Territory	
Regional Health Services **Planning** Borroloola Region (completed) East Arnhem (competed) Katehrine Remote Region (completed) Katherine (completed) Ngaanyatjarra Santa Theresa Southern Barkly Urapuntja (completed) **Service Delivery** Borroloola RHS (not yet operational) Kakadu Region RHS Katherine Remote Region (not yet operational) Katherine West RHS Urapuntja (not yet operational) Youth Wellbeing Project RHS (not yet operational)	**Multipurpose Services** Belyuen MPS
Tasmania	
Regional Health Services <u>Planning</u> Bruny Island (completed) Glamorgan / Spring Bay (completed) Kentish Municipality (completed) West Coast (completed) **Service Delivery** Break O'Day RHS Bruny Island RHS (not operational) Circular Head RHS Dorset RHS Flinders Island RHS George Town RHS Glamorgan / Spring Bay RHS Huon Valley RHS Kentish RHS King Island RHS Southern Midlands RHS Tasman Peninsular Counselling RHS West Coast RHS	**Multipurpose Services** Beaconsfield MPS Campbell Town MPS Tasman MPS (not operational)

National	
Regional Health Services **Service Delivery** Lifeline Project RHS	**Multipurpose 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: E02-236

OUTCOME 5: RURAL HEALTH CARE

Topic: REMOTE AND RURAL NURSING RE-ENTRY AND UPSKILLING SCHOLARSHIP SCHEME

Hansard Page: CA 202-03.

Senator West asked:

Can you provide a breakdown of where the 60 Re-entry and Upskilling scholarship grants were awarded by State and Territory?

Answer:

Remote and rural re-entry scholarship recipients in 2001 by State.

State	**Total**
New South Wales	3
Northern Territory	1
Queensland	27
South Australia	9
Tasmania	3
Australian Capital Territory	8
Western Australia	9
Total	**60**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-161

OUTCOME 5: RURAL HEALTH CARE

Topic: ALLIED HEALTH CARE PROFESSIONALS IN RURAL AREAS

Written Question on Notice

Senator Evans asked:

What is known about the rural availability of Speech therapists, Physiotherapists, Podiatrists, Dietitians and Occupational therapists? Please provide figures.

Answer:

The data available is somewhat dated and patchy due to the following factors:

- Australian Institute of Health and Welfare Health Labour Force Reports are based on information from surveys undertaken in cooperation with state registration boards. Only physiotherapists have registration boards in all states and territories. Other allied health professions are registered in some states but not all.

  The most recent data is from 1998 and is available for only physiotherapists and occupational therapists. A Labour Force Report on podiatrists is currently being finalised and is expected to be released in 4-6 weeks.

- Australian Bureau of Statistics data from the 1996 ABS Census provides a more comprehensive view of the level of employed allied health professionals. Data from the 2001 census is not expected to be available until November 2002.

- The discrepancies between the two sets of data arises from the fact that one is derived from registration data and the other from census data identifying employed professionals. It is likely that not all registered allied health professionals will be employed in the profession at any particular time.

	Capital City/Other Metropolitan **(RRMA 1 – 2)**	**Large Rural Centres to Other Remote Areas (RRMA 3 –7)**
Physiotherapists	9,077	2,227
Occupational therapists	2,419	696

Source: AIHW, 1998

Note: Physiotherapists – Data for Tasmania have been imputed from registrations, and the pattern of data for other States and Territories; Occupational therapists – Data does not include NSW, SA or TAS, and includes estimates for VIC and ACT.

	Capital city RRMA 1	Other Metro **RRMA 2**	**Large centres RRMA 3**	**Small centres RRMA 4**	**Rural other RRMA 5**	**Remote RRMA 6**	**National**
Physiotherapists	6601	604	470	330	761	99	8865
Dietitians	1239	201	91	57	109	16	1713
Occupational therapists	3190	327	282	162	334	52	4347
Podiatrists	1097	93	98	65	96	6	1455
Speech pathologists	1680	158	148	106	198	38	2328

Source: ABS, Census tables Allied health Professionals 1996

Commonwealth Department of
Health and Ageing

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Senator S. C. Knowles
Chair
Senate Community Affairs Legislation Committee
Suite No S1 32, Telelift No 2-6
Parliament House
CANBERRA ACT 2600

Dear Senator Knowles

I am writing to you in relation to the answers I provided to the Senate Community Affairs Legislation Committee hearing held on 5 June 2002.

At the hearing I said that indigenous health workers are trained by Australian Hearing on behalf of the Office for Aboriginal and Torres Strait Islander Health (OATSIH) and they use the existing locations of their hearing centres.

I have confirmed with Australian Hearing that the location of the training is primarily determined by the location of those to be trained. This means that venues are chosen in discussion with the local or host Aboriginal Medical Service. Existing Australian Hearing sites are used, but only if the location is appropriate to the group to be trained.

Yours sincerely

Jenny Hefford
National Manager
Office of Hearing Services

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: E02-241

OUTCOME 6: HEARING SERVICES

Topic: COCHLEAR SPEECH PROCESSORS

Hansard Page: CA 213

Senator McLucas asked:

How many replacement processors do we get out of $1.4 million over 4 years?

Answer:

$1.9 million was made available in the 1997-98 Budget over 4 years to enable replacement of Cochlear implant speech processors for eligible children. This funding enabled replacement of 443 speech processors.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-242

OUTCOME 6: HEARING SERVICES

Topic: COCHLEAR SPEECH PROCESSORS

Hansard Page: CA 214

Senator McLucas asked:

(a) How many children get their implants under private health insurance?
(b) How many children get their implants through the Commonwealth program?
(c) How many children get their implants through State Government programs?

Answer:

(a) Cochlear Limited have provided estimated sales figures which indicate that approximately 140 children per annum receive cochlear implants, of which around 70 are under private health insurance,

(b) The Commonwealth program, administered by Australian Hearing Services, does not provide initial cochlear implants. The program provides replacement cochlear speech processors. Over the four years from 1997-98 to 2000-01, 494 replacement and upgraded speech processors were made available to eligible children at a total cost of $1.2 million.

(c) Cochlear Limited have provided estimated sales figures which indicate that approximately 70 children per annum receive cochlear implants through State and Territory Government programs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-243

OUTCOME 6: HEARING SERVICES

Topic: HEARING SERVICES PROVIDED TO INDIGENOUS CHILDREN

Hansard Page: CA 215

Senator McLucas asked:

How many indigenous and non-indigenous children have accessed an AHS service in the current financial year?

Answer:

From 1 July 2001 to 31 March 2002, 1,052 children identified as indigenous have accessed an AHS service. 22,558 children who accessed an AHS service did not identify as indigenous.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-244

OUTCOME 6: HEARING SERVICES

Topic: IPTAS – ISOLATED PATIENTS TRAVEL ASSISTANCE SCHEME

Hansard Page: CA 216

Senator West asked:

Is someone attending an Australian Hearing Services clinic eligible for travel under IPTAS?

Answer:

Responsibility for IPTAS was passed to State and Territory governments through Act No 94 of 1986, the Health Legislation Amendment Act (No. 2) 1986. It was repealed with date of effect from 1 January 1987.

IPTAS covered travel to specialists or a consultant physician.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-245

OUTCOME 6: HEARING SERVICES

Topic: HEARING SERVICES PROVIDED TO INDIGENOUS COMMUNITIES

Hansard Page: CA 217

Senator West asked:

Do we know how many audiologists serve indigenous communities in the Northern Territory?

Answer:

Australian Hearing has five audiologists who deliver services in the Northern Territory, including to indigenous communities.

There are other privately employed audiologists working in the Northern Territory.

Tabled at hearing

Aboriginal and Torres Strait Islander Health Workforce National Strategic Framework, May 2002, Australian Health Ministers' Advisory Council

The report is accessible at:
http://www.health.gov.au/oatsih/pubs/wrkstrgy1.htm

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-162

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER HEARING STRATEGY

Written Question on Notice

Senator Evans asked:

February Senate Estimates was informed that a review of this strategy was in its final stages. On May 22 an OATSIH officer said that there had been a few delays but it should soon be available.

(a) Has the review been finalised? If not, why not? When will it be available?
(b) What are the recommendations of the review? Does the review recommend the provision of more services to remote communities? If not, why not?

Answer:

(a) The report is currently being finalised. It synthesises consultant's findings, submissions received and opinion of experts in the Aboriginal and Torres Strait Islander hearing services.

The Department has sought to strategically consolidate key issues and this has resulted in delays being experienced. Throughout this process the Department has endeavoured to consolidate a way forward through further stakeholder input.

It is anticipated that the Report will be finalised and considered by the Ministers, Senator Patterson and Minister Andrews, at the completion of this necessary refinement process. The Ministers will decide on whether the report is to be made public.

(b) As the Report has not been completed, recommendations are unavailable at this stage.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-163

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: INFANT MORTALITY AND SIDS

Written Question on Notice

Senator Evans asked:

The infant mortality rates for Indigenous infants in 2000 was 13.6 deaths per 1000 live births. This is three times the rate for non-Indigenous babies which is 4.6 per 1000 live births. In the Northern Territory the rates are around 23 deaths per 1000 live births.

(a) What is being done to address this situation?
(b) How much money is being spent?

Answer:

(a) Whilst the disparity between Indigenous and non-indigenous infant mortality is still unacceptable, Indigenous infant mortality has declined significantly in the last 30 years. In the NT for example the figure was approximately 150 deaths per 1000 live births in the 1960s. Much of this improvement has been attributed to high hospitalisation rates, increased access to antibiotics and primary health care, increased expenditure on housing, sewerage and water, and the decreased prevalence of severe malnutrition. The determinants of infant morbidity and mortality are complex but include poor nutrition, general health during pregnancy and late presentation for antenatal care.

Many of the socio-economic and environmental determinants of health lie outside the direct control of the health system. There is evidence that antenatal and related population health programs, provided as a component of comprehensive primary health care, can reduce complications of pregnancy, the incidence of low birth-weight and perinatal deaths. Improving access to antenatal, maternal and child health programs is a high priority to reduce infant mortality, morbidity and poor early growth in Indigenous babies and prevent the short and long term implications of these factors.

The Government contributes towards the provision of antenatal programs for Indigenous families through its funding of Aboriginal community controlled health organisations. The Commonwealth emphasis is on improved access to primary health care for Aboriginal and Torres Strait Islander people, to be achieved in two ways:

- expansion of Aboriginal community controlled primary health care services; and
- improved orientation of mainstream services to meet the needs of Aboriginal and Torres Strait Islander people.

Further expansion of community controlled primary health care services for Aboriginal and Torres Strait Islander health is aligned with the continued development of regional planning processes, which are the mechanism for identifying agreed priority areas of need. The expansion of primary health care through the increased federal budget commitment to Aboriginal and Torres Strait Islander health will support the continuation and improved development of ante-natal and post-natal programs in Aboriginal community controlled health organisations.

The Department is committed to the implementation of the Primary Health Care Access Program (PHCAP). The PHCAP program establishes a framework for the expansion of comprehensive primary health care services with the aim to increase and enhance both the resources available for primary health care and the effectiveness of existing service delivery arrangements.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is currently facilitating the development of national policy for Aboriginal and Torres Strait Islander maternal and child health which will support the improvement of systemic responses to the holistic physical, emotional and social wellbeing of Aboriginal and Torres Strait Islander women and children to effect an improvement in health outcomes such as infant mortality.

The Department's Population Health Division (PHD) is also currently in the process of developing a strategic approach to mainstream maternal and child health needs and participating on an interdepartmental taskforce led by the Department of Family and Community Services to develop a National Agenda on early childhood. An Indigenous IDC taskforce has also recently been convened and has OATSIH representation. It is envisaged that an Indigenous maternal and child framework will be developed to complement this mainstream initiative.

The Commonwealth Government has invested in improvements to national information and data with a major focus being on the role of the Australian Institute of Health and Welfare. One of the particular activities that are funded through the auspices of AIHW is the National Perinatal Statistics Unit (NPSU). The NPSU has developed a number of data systems on women's reproductive health services and pregnancy outcomes services that cover the period from conception to birth and up to one year. The NPSU publishes regular reports on mothers and babies including a separate report on Indigenous mothers and babies.

National performance indicators and targets for Aboriginal and Torres Strait Islander Health have been agreed to by all Australian Health Ministers. The indicators include measures relating to still births, infant deaths and low birth weight among Indigenous children.

Additionally, the Commonwealth Government contributes towards the capacity of States and Territories to maintain and improve the general level of Australia's health through broad Public Health Outcome Funding Agreements (PHOFAs). The base funding in the PHOFAs resulted from the broadbanding of Commonwealth funding to States and Territories for eight established public health programs (SPPs), including the National Women's Health Program and the Alternative Birthing Services Program.

The Commonwealth has contributed towards the promotion of consumer choice in birthing services through providing incentive funds for the establishment of birthing centres in States and Territories under the Alternative Birthing Service Program. ABSP funds also contributed towards the establishment of culturally appropriate birthing services for Indigenous women.

The current PHOFAs are for a five-year period, 1999-2004 and will provide in excess of $900 million to States and Territories during that time. These funding Agreements are designed to provide States and Territories with the flexibility to 'mix and match' Commonwealth financial assistance to meet the varying needs of their respective populations while at the same time ensuring that the States and Territories remain part of a nationally coordinated effort in areas of high national priority. Decisions about funding allocations to women's health services, including birthing and pregnancy support services are the responsibility of State and Territory health authorities.

The Government recognises the importance of building on the many already successful locally initiated projects in communities, which have effected an improvement in infant health outcomes. The following provide a snapshot of exemplar sites for Aboriginal and Torres Strait Islander maternal and child health programs:

- the Northern Territory "*Strong Women Strong Babies Strong Culture Project*" has had a measurable impact on infant mortality and morbidity rates and complements routine antenatal care delivered through community health centres across the Northern Territory;

- the Ngaanyatjatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council's " *Strong Women Strong Families/Nutrition Project for Mothers and Babies*" has evolved since its inception in 1996 to taking a comprehensive primary health care approach to nutrition and incorporating additional services around maternal and child health and child protection, involving clinical service delivery, case management, education and prevention. This project has also reported a decline in infant mortality and morbidity rates since its commencement; and

- The Townsville Aboriginal and Torres Strait Islanders Health Service *"Mums and Bubs"* program has been able to demonstrate over a eighteen months period improved pregnancy outcomes with an 8% reduction in pre-term births, a 7% reduction in low birth weight babies and a 4.2% reduction in peri-natal deaths.

- The Department, together with the Department of Education Training and Youth Affairs (DETYA), Attorney General's Department and the Department of Family and Community Services, provide funding to the Telethon Institute for Child Health Research to conduct the "Western Australian Indigenous Child Health Survey". This project has surveyed households and schools to collect health information and data on Aboriginal children in Western Australia aged 0-17, and their families. The project commenced in 2000, and additional funding has been approved to enable the required sample survey target numbers to be achieved. Data has now been collected on approximately 4,000 children and is currently being analysed. This data may have general application.

- The Kulunga Research Network, is in the early stages of developing a collaborative, maternal and child health research, information and training network involving the West Australian Institute of Child Health Research in Perth and member services of the West Australian Aboriginal Community Controlled Health Organisation (WAACCHO). The Network manages the *Bibbulung Gnarneep - Building Solid Kids Project* Project. The Project involves a study of a cohort of mothers during pregnancy and their babies during the first two years of life looking at SIDS risk factors and other defining health issues. A second phase involves home visiting to provide access to medical appointments and regular antenatal checks, information and education (reducing the risk of SIDS) and to provide cultural support and advocacy.

(b) Total expenditure on comprehensive primary health care services to Aboriginal and Torres Strait Islander communities was approximately $181.5 million in 2001-02, and $212.5 million has been allocated for 2002-03.

The Primary Health Care Access Program (PHCAP) was announced in the 1999-2000 Budget, with funding of $78.8 million over four years. The 2001-02 Budget announced an additional $19.7 million each year from 2003-04, taking the total recurrent base for the program to $54.8 million per annum.

Approximately $75,000 on an annual basis has been provided to the NPY Women's Council for their Nutrition Project for Mothers and Babies.

On 12 June this year, the Minister of Health and Ageing, Senator Kay Patterson announced a commitment to fund the Townsville Aboriginal and Islanders Health Service $145,000 for the 2002/03 year to support the continuation of their *"Mums and Bubs"* program.

Total OATSIH contribution to the Telethon Institute for Child Health Research in 1999/2000, 2001/2002, 2002/2003 is $1,551,151 and to the Kalunga Research Network in 2001/02 and 2002/03 is $120,000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-164

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: INFANT MORTALITY AND SIDS

Written Question on Notice

Senator Evans asked:

(a) What is the SIDS rate in Indigenous infants?
(b) How does this compare with the SIDS rate in the non-Indigenous population?
(c) What is being done to address this specific issue?
(d) How much money is spent on this?

Answer:

(a) Between 1998 and 2000, the average SIDS death rate for Aboriginal and Torres Strait Islander infants was 253.2 per 100,000 live birth which is nearly five times higher than for non-Aboriginal and Torres Strait Islander infants (AIHW, *Australia's Children,* 2002, p100).

(b) Between 1998 and 2000 the average SIDS death rate for non-Aboriginal and/or Torres Strait Islander infants was 51.9 per 100,000 live births (ibid).

(c) Knowledge of the risk factors for Sudden Infant Death Syndrome (SIDS) and their combined influences are still incomplete, particularly in relation to Aboriginal and Torres Strait Islander Australians. Generally, the number of cot deaths in Australia have drastically reduced over the last few years which is primarily a result of increased public awareness due to successful parent and professional education campaigns. Such campaigns have not had the same impact on the rates of SIDS in Aboriginal and Torres Strait Islander communities. The NHMRC has therefore funded a number of research projects specifically and/or generally examining SIDS in Aboriginal and Torres Strait Islander populations.

The evidence suggests that ante-natal and related population health programs, provided as a component of comprehensive primary health care, can reduce complications of pregnancy, the incidence of low birth-weight and perinatal deaths. Given the unacceptably high rates of infant mortality (including SIDS) and morbidity, the incidence of low birthweight and poor early growth in Indigenous babies and the short and long-term health implications of these factors, improving access to antenatal, maternal and child health programs is a high priority. Specific funding is therefore provided for Aboriginal Community Controlled Health Services for this purpose.

The Department is further committed to the implementation of the Primary Health Care Access Program (PHCAP). The PHCAP program will establish a framework for the expansion of comprehensive primary health care services, aiming to increase and enhance both the resources available for primary health care and the effectiveness of existing service delivery arrangements.

The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is currently developing a national Aboriginal and Torres Strait Islander Maternal and Child Health Framework which will support the improvement of systemic responses to the holistic physical, emotional and social wellbeing of Aboriginal and Torres Strait Islander women and children to effect an improvement in health outcomes such as infant mortality.

The Department's Population Health Division (PHD) is currently in the process of developing a strategic approach to mainstream maternal and child health needs. The OATSIH Framework will be developed and implemented complementing this initiative.

The Department provides significant funding, matched by State and Territory health departments, for population health issues through the Public Health Outcome Funding Agreements (PHOFAs), this funding also support SIDS activities. For example, Stillborn and Neonatal Death Support (New South Wales), a charitable organisation associated with the NSW Sudden Infant Death Association previously applied for and received assistance from the State Government through similar funding mechanisms.

The Department is supportive of educational initiatives undertaken by SIDS Australia such as the information brochure for Indigenous women, "Taking Care of Your Baby" (2001).

The Kulunga Research Network, is in the early stages of developing a collaborative, maternal and child health research, information and training network involving the West Australian Institute of Child Health Research in Perth and member services of the West Australian Aboriginal Community Controlled Health Organisation (WAACCHO). The Network manages the *Bibbulung Gnarneep - Building Solid Kids Project* Project. The Project involves a study of a cohort of mothers during pregnancy and their babies during the first two years of life looking at SIDS risk factors and other defining health issues. A second phase involves home visiting to provide access to medical appointments and regular antenatal checks, information and education (reducing the risk of SIDS) and to provide cultural support and advocacy.

(d) Total expenditure on comprehensive primary health care services to Aboriginal and Torres Strait Islander communities was approximately $181.5 million in 2001-02, and $212.5 million has been allocated for 2002-03.

The Primary Health Care Access Program (PHCAP) was announced in the 1999-2000 Budget, with funding of $78.8 million over four years. The 2001-02 Budget announced an additional $19.7 million each year from 2003-04, taking the total recurrent base for the program to $54.8 million per annum.

The Department continues to fund SIDS research through the National Health and Medical Research Council (NHMRC). In 2002, the NHMRC has directed nearly $2 million for research investigating the causes, risk factors and prevention strategies relating to peri-natal and infant death. A number of the research projects specifically or generally examine SIDS in relation to Aboriginal and Torres Strait Islander populations.

Total OATSIH contribution to the Telethon Institute for Child Health Research in 1999/2000, 2001/2002, 2002/2003 is $1,551,151 and to the Kalunga Research Network in 2001/02 and 2002/03 is $120,000.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-165

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL HEALTH - END STAGE RENAL DISEASE

Written Question on Notice

Senator Evans asked:

The incidence of end-stage renal disease for Aboriginal people in the Northern Territory is some 18 times that of non-Aborigines and it is doubling every 4 years. The number on dialysis treatments is doubling every two years. Their survival rates on dialysis and after transplants is poor.

(a) What is being done to address this?

The program to treat Tiwi people with early renal disease with ACE inhibitors (medicines to lower blood pressure) has demonstrated that good compliance can be achieved with a consequent reduction in the deterioration of kidney function.

(b) Are there plans to extend this program?
(c) If not, why not?
(d) Is there a waiting list for Aboriginal and Torres Strait Islander people to access dialysis treatment?

Answer:

(a) Renal replacement therapies, transplantation and dialysis (haemodialysis or peritoneal), are the available treatments for people with end stage renal disease. Delivery of these services is primarily a State and Territory responsibility. However, in recognition of the significance of this health issue among Indigenous Australians, the Commonwealth has provided the capital funds to build a satellite dialysis unit on the Tiwi Islands. Anecdotal information indicates that compliance improves and morbidity is reduced when the service is delivered close to where the patient lives.

The Commonwealth's primary responsibility in this area is to strengthen the capacity of primary care services to deliver comprehensive primary health care including early detection and management of chronic diseases such as renal disease amongst Indigenous Australians.

(b) Dr Wendy Hoy's research in the late 1990s on the Tiwi Islands demonstrated that screening and treatment with medication significantly reduced progression onto ESRD and reduced cardiovascular death (W Hoy, et al, *Reducing premature death and renal failure in Australian Aboriginals- a community based cardiovascular and renal protective program*, MJA 172, 473-78, 2000).

The Tiwi Health Board formally took responsibility for the renal treatment program in July 2000 (now chronic diseases program). This has been funded through their primary health care service provision budget.

The OATSIH is funding three pilot sites in the Northern Territory, where the model detection and management of renal and other chronic diseases in Indigenous primary health care settings. These sites will be independently evaluated over 2002-04 and the results will inform the development of a chronic disease framework being undertaken by the OATSIH.

(c) See (b).

(d) The provision of renal dialysis services is a State and Territory responsibility. Our understanding is that there is no waiting list as people needing treatment are dialysed as required.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-166

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL HEALTH - RHEUMATIC FEVER

Written Question on Notice

Senator Evans asked:

Aboriginal communities suffer from the highest rates of rheumatic fever in the world.

(a) What is being done to address this?
(b) What funds have been allocated to this?

Answer:

(a) The Commonwealth supports the provision of primary health care through funding for comprehensive primary health care infrastructure and service delivery. These Aboriginal community controlled health services deliver services that minimise the impact of rheumatic fever and rheumatic heart disease on the population.

Since 1997 the Department has provided funding towards a Rheumatic Heart Disease Register in the Top End of the Northern Territory. In 2000 the Register was extended to Central Australia. The registry has had a key role in upgrading and maintaining the quality of treatment and management of Aboriginal children and young adults with rheumatic heart disease in the Northern Territory.

The Commonwealth funds the installation and maintenance of patient information and recall systems (PIRS) in Aboriginal community controlled health services across Australia. PIRS have the ability to maintain care plans and service level registers for rheumatic heart disease.

(b) Total Commonwealth expenditure on comprehensive primary health care services to Aboriginal and Torres Strait Islander communities was approximately $181.5 million in 2001-02, and $212.5 million has been allocated for 2002-03.

In November 1997 the Department ($79,960) and the Australian Institute of Health and Welfare ($73,270) provided funding for the two year establishment phase of a rheumatic heart disease control program in the Top End of the Northern Territory. In February 2000, the Commonwealth and the AIHW agreed to provide an additional $35,000 to extend the establishment phase of the program.

In February 2002, the Commonwealth agreed to fund the Rheumatic Heart Disease Register an additional $255,000 over two years (12 months for the Top End and 24 months for Central 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: E02-167

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL HEALTH - STREPTOCOCCI

Written Question on Notice

Senator Evans asked:

At any one time, up to 60% of Aboriginal children in bush schools have skin sores infected with Group A Streptococci. This infection has been linked to kidney problems.

(a) What is being done to address this?
(b) What funds are allocated to this?

Answer:

(a) The Commonwealth supports the provision of primary health care through funding for comprehensive primary health care infrastructure and service delivery. These Aboriginal community controlled health services provide child health screening and treatment services for childhood skin infection (including skin sores infected with Group A Streptococci) and its precursors.

The Office for Aboriginal and Torres Strait Islander Health collaborated with the Australasian Dermatological Research and Education Foundation and the National Aboriginal Community Controlled Health Organisation in the production of *A Handbook of Skin Conditions in Aboriginal Populations of Australia* (Dr Alan Green, 2001). There has been a positive response to the Handbook from health professionals with over 1500 copies of the publication distributed to dermatologists, general practitioners and Aboriginal community controlled health services. The Handbook includes information to help in the diagnosis of skin conditions related to Group A Streptococci.

(b) Total Commonwealth expenditure on comprehensive primary health care services to Aboriginal and Torres Strait Islander communities was approximately $181.5 million in 2001-02, and $212.5 million has been allocated for 2002-03. In 2001-02 OATSIH contributed $60,000 funding towards the costs of editing and publication of *A Handbook of Skin Conditions in Aboriginal Populations of 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: E02-248

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: STOCKTAKE OF HEARING SERVICES IN INDIGENOUS COMMUNITIES

Hansard Page: CA217

Senator West asked:

Can the committee have a copy of the Review of Hearing Services being offered to Aboriginal and Torres Strait Islander people when it is complete?

Answer:

A copy of the Hearing Report will be considered by Ministers Patterson and Andrews who will decide on whether the report is to be made public.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001-2002, 5 & 6 June 2002

Question: E02-002

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: ABORIGINAL AND TORRES STRAIT ISLANDER HEARING

Hansard Page: CA 218 - 219

Senator West asked:

(a) How many Aboriginal Health workers have had training in audiology/ear health?
(b) To what level are they trained? Is it just to basic screening level?
(c) Can you provide information on whether Aboriginal Health Workers trained in hearing health are still working in the system and using those skills, or have moved up the health system as it has been part of their progression, using a sample of three remote and three urban Commonwealth funded services?

Answer:

(a) The Commonwealth contracts Australian Hearing Services to provide hearing training to at least two health workers from each of the 115 participating Aboriginal Community Controlled Health Services, in all states and territories, except the Northern Territory. This training is delivered in two, one week, blocks.

In the Northern Territory, the Commonwealth contracts the Northern Territory Aboriginal Hearing Program to provide training to Aboriginal Health Workers in Aboriginal Community Controlled Health Services. This training is provided in a once a year workshop format.

Since the inception of the program a total of 389 commenced training with 306 completing both training modules with Australian Hearing Services. Of the Health Workers who completed the two stages of training, 153 remain in the sector.

Available information indicates that in the Northern Territory over 50 Aboriginal Health Workers accessed training, with 29 completing short courses and 5 completing all modules offered, over the two year period 2000 to 2001. No aggregate information exists that would provide an indication of whether Aboriginal Health Workers accessing training remain in the health sector.

(b) The Australian Hearing Services training program is customised and designed to equip health workers with knowledge, skills and understanding of the theoretical foundations of anatomy, physiology and pathology, practical use of audiometic equipment such as otoscopy and tympanometry, childhood screening and health promotion activity.

The Northern Territory training program comprising modules that cover anatomy and physiology, conductive hearing loss, ear disease, medical management of ear disease, treatment and management of middle ear disease, screening, practical use of audiometric equipment including otoscopy and tympanometry, health promotion and mobilising communities for action.

(c) A survey has been conducted sampling three urban and three remote medical services.

It was found that the retention rate for Aboriginal Health Workers trained in hearing health was 60% for designated Hearing Health Worker positions. Overall only 13% of Aboriginal Health Workers trained in hearing health have left their respective services, but they may be using these skills in another position or service. All Aboriginal Health Workers that have been trained in hearing health have remained in the health system. Data on career progression to eg. nursing or audiology is not available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2001-2002, 5 & 6 June 2002

Question: E02-001

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: NUMBER OF ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH WORKER POSITIONS IN COMMONWEALTH FUNDED ABORIGINAL PRIMARY HEALTH CARE SERVICES

Hansard Page: CA 220

Senator McLucas asked:

(a) How many Aboriginal Health Workers are employed in Commonwealth funded Aboriginal medical services?
(b) Does the Department have information on the proportion of Aboriginal Health Workers who have received relevant training or have relevant professional qualifications?

Answer:

(a) In 1998-1999, 523 'full time equivalent' Aboriginal and Torres Strait Islander Health Workers were employed in 110 Commonwealth funded Aboriginal primary health care services.

(These figures are collected through Service Activity reporting (SAR) on full time equivalent positions in Commonwealth funded primary health care services. Please note that the SAR uses 'full time equivalent' positions to describe workforce data and does not collect information on the number of staff employed. The 1998-1999 SAR is the most recent publicly available data that can be released.)

(b) The SAR does not collect data on the training level of Aboriginal Health Workers. However, the Department has commissioned a national review of Aboriginal and Torres Strait Islander Health Worker Training, which drew on state-based reviews. The review indicates there is enormous variability in the proportion of Aboriginal Health Workers across States, ranging from 30% to 80%, who have attained relevant professional qualifications.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-229

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: Age profile of Aboriginal Health Workers

Hansard Page: CA 220

Senator McLucas asked:

Can you provide a copy of the AIHW Workforce survey which supports those (retention level of Aboriginal health workers) trends?

Answer:

The AIHW Health Workforce series does not include Aboriginal Health Worker statistics. It is an annual survey of doctors, nurses and selected allied health professional groups but does not include Aboriginal Health Workers.

The sample of Aboriginal Health Workers analysed in the National Review of Aboriginal and Torres Strait Islander Health Worker Training showed that 47 per cent of the sample were aged 41 years and above. 53 per cent of the sample was between 21 to 40 years of age. There is currently no data available on the relationship between the age profile of Aboriginal Health Workers and retention rates.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-253

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: MUTUAL RECOGNITION OF HEALTH INDUSTRY WORKERS' QUALIFICATIONS

Hansard Page: CA 314

Senator Patterson offered to provide information on a project for mutual recognition of health industry workers' qualifications she launched for Dr Nelson, Minister for Education, Science and Training.

Answer:

On 5 April 2002 Senator Patterson launched the Health Training Package on behalf of the Minister for Education, Science and Training.

The Health Training Package outlines a common training framework of vocational education and training (VET) for workers in the health industry. Industry Training Packages, part of the VET sector reform process, include industry developed sets of national qualifications and competency standards applying to non-university trained workers in a discrete industry. The VET sector reforms also include a national framework for quality assurance – The Australian Quality Training Framework – which allows for mutual recognition across States and Territories of both training providers and qualifications.

The Health Training Package was developed by Community Services and Health Training Australia (CSHTA), the national industry training advisory body for the community services and health industry. The first stage covered an existing workforce of approximately 150,000 health industry workers including: general health service workers, ambulance workers, dental assistants, dental technology and dental prosthetics workers and complementary and alternative health care workers. A second stage covering health technicians is expected to be endorsed in 2002, and a third stage covering population health workers and Aboriginal health workers is currently being developed.

The Health Training Package allows for flexible career paths and course structures through flexible packaging of competency standards into qualifications, and includes guidelines for assessment against the competency standards. A total of 52 qualifications is included covering Certificate Levels II to IV, Diploma and Advanced Diploma qualifications.

The Health Training Package addresses the health industry workforce profile, particularly the high representation of mature age workers, often with extensive experience but lacking in formal qualifications. Health industry workers will be able to receive formal recognition for existing skills and on-the-job training experience. Recognition of a qualification under the Health Training Package applies nationally, permitting greater job mobility, transfer and career choices.

The Health Training Package does not currently provide for career paths or articulation between Training Package qualifications and enrolled nurse training. The national competency standards for enrolled nurses have been developed by the Australian Nursing Council Incorporated (ANCI) and the State/Territory Nurses Boards set educational requirements for enrolled nurses to be registered within the State/Territory. The National Review of Nursing Education 2002, jointly commissioned by the Minister for Health and Ageing and the Minister for Education Science and Training, released its report on 16 September 2002. Recommendation 21 addresses enrolled nurse competencies and recommends that the ANCI and CSHTA meet as a matter of urgency to ensure that ANCI competencies for enrolled nurses are incorporated in existing or new Training Packages for Health and Community Services. This would facilitate articulation by health industry workers into enrolled nurse training.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question:E02-004

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE USE - PETROL SNIFFING

Hansard Page: CA 224

Senator Buckland asked:

(a) Could the Department provide some references by Maggie Brady on Petrol Sniffing?
(b) Could the Department provide to the committee with a copy of the written submission to the South Australian Coronial Inquiry into petrol sniffing?

Answer:

(a) Attached is a copy of *Petrol Sniffing and Other Solvents: A Resource Kit for Aboriginal Communities* (2000), developed by the Aboriginal Drug and Alcohol Council of South Australia, which aims to assist Aboriginal and Torres Strait Islander community's responses to petrol sniffing.

The kit includes the following resources:
- *The Brain Story* (Developed by Petrol Link Up)
- *Petrol Sniffing in Aboriginal Communities: A Review of Interventions* by Peter d'Abbs and Sarah MacLean
- *Petrol Sniffing and Other Solvents: Plain Language Summary (book 1)*
- *Petrol Sniffing and Other Solvents: Information for Health and Community Workers (book2)*
- *Petrol Sniffing and Other Solvents: Community Development (book 3)*
- *Petrol Sniffing and Other Solvents: For Health and Community Workers (book 4)*

There are a number of other references that the Senator may wish to consider obtaining. These include:

- Maggie Brady (1992) *Heavy Metal: The Social Meaning of Petrol Sniffing in Australia*. Canberra: Aboriginal Studies Press

- Maggie Brady (1995) *An Overview of the prevalence of petrol sniffing and related mortality*, in Workshop on lead and hydrocarbon toxicity from chronic petro inhalation. Canberra: The Drug Offensive, Australian Government Publishing Service

- Maggie Brady (1995) *The Prevention of Drug and Alcohol abuse among Aboriginal People: Resilience and Vulnerability. Australian Capital Territory*: Australian Institute of Aboriginal and Torres Strait Islander Studies Research Section, occasional paper no. 2/1995

- Maggie Brady (1997) *Aboriginal Drug and Alcohol Use: Recent Developments and Trends*. Australian and New Zealand Journal of Public Health 21 (1): 3-4

- Maggie Brady and Paul Torzillo (eds) 1995. *Workshop on lead and hydrocarbon toxicity from chronic petrol inhalation*. Canberra: The Drug Offensive, Australian Government Publishing Service.

- d'Abbs PHN 1990. *Responding to aboriginal substance misuse: a review of programs conducted by the Council for Aboriginal Program Services (C. A. A. P. S), Northern Territory.* Darwin: NT Department of Health and Community Services.

- D'Abbs P. Togni S and Crundall I 1996. *The Tennant Creek Liquor Licensing Trial August 1995 – February1996: an evaluation*. Darwin: Menzies School for Health Research, occasional paper no. 2/96.

(b) Attached is a copy of the submission to the South Australian Coronial Inquiry into petrol sniffing.

[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: E02-003

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE USE - BREAKDOWN OF FUNDING

Hansard Page: CA 225

Senator WEST asked:

What is the breakdown of OATSIH funded programs for substance use services, by State/Territory?

Answer:

Total funding outlays for Aboriginal and Torres Strait Islander health of approximately $201 million (01-02) are administered though the Office for Aboriginal and Torres Strait Islander Health. Of these funds approximately $20 million (or 10%) are committed for substance use services/activities and the Comgas Scheme. Specific substance use funding allocations for 2001/02 include:

- Approximately $16.5 million managed directly by OATSIH State/Territory Offices to support sixty five (65) Aboriginal and Torres Strait Islander substance use services. Forty two (42) of these services are stand alone substance use services with the remaining twenty three (23) funded as part of Aboriginal and Torres Strait Islander primary health care services (see table 1).
- $1 million for the Comgas Scheme.
- $2.3 million managed at the national level to support the development of research, infrastructure and resources.

Jurisdiction	**Funding**
National Initiatives	$3.3 m (including Comgas)
New South Wales	$3.0 m
Victoria	$1.1 m
Queensland	$3.1 m
Northern Territory	$2.9 m
South Australia	$3.0 m
Western Australia	$2.2 m
Australian Capital Territory	$0.2 m
Tasmania	$1.0 m
TOTAL	**$19.8m**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-090

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE USE - EDUCATION

Hansard Page: CA 225

Senator Buckland asked:

Are there programs in the Aboriginal education curriculum to bring the dangers of petrol sniffing and substance abuse into that curriculum, into their health and education programs?

Answer:

State and Territory education authorities have primary responsibility for school education, including the development and implementation of health education policy and curriculum and supporting programs. The Department of Health and Ageing (DoHA) however, after consultation with the Department of Education, Science and Training (DEST), is able to provide Senator Buckland with some general information on how petrol sniffing is addressed by health and education programs.

While the education departments of each State and Territory run programs with the aim of preventing uptake and reducing harm from licit and illicit drugs, there are few programs specifically designed to address petrol sniffing/inhalant use. There is wide consensus among jurisdictions supporting current research indicating that educating students about the effects of inhaling volatile substances makes them inclined to experiment. When young people become aware that inhalants are a cheap and easily accessible way of inducing a state of psychoactivity, education can result in a detrimental "advertising" effect.

Several education jurisdictions have developed drug education resources specifically for Aboriginal and Torres Strait Islander students including New South Wales (*Healing Time*). The Northern Territory education department is currently developing a Petrol Sniffing Unit to complement its Drug Education resource for Indigenous School Communities.. This project is in very early stages however, and as yet there is little information 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: E02-091

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SUBSTANCE USE

Hansard Page: CA 227

Senator McLucas asked:

How much money is being spent by the Department on alcohol and substance use (including tobacco) programs for Indigenous peoples, by State/Territory?

Answer:

Total Departmental funding of $22.33 million (01-02) consists of funds sourced from a range of initiatives and programs.

a) Office for Aboriginal and Torres Strait Islander Health:

Jurisdiction	**Funding (01-02)**
National Initiatives	$3.3 m (including Comgas)
New South Wales	$3.0 m
Victoria	$1.1 m
Queensland	$3.1 m
Northern Territory	$2.9 m
South Australia	$3.0 m
Western Australia	$2.2 m
Australian Capital Territory	$0.2 m
Tasmania	$1.0 m
TOTAL	**$19.8 m**

b) Population Health Division:

Population Health Division provides funding to specific Aboriginal and Torres Strait Islander projects totaling $1.18 million (01-02) under the National Illicit Drug Strategy.

These funds are represented by jurisdiction in the following table.

Jurisdiction	**Funding (01-02)**
New South Wales	$0.47 m
Victoria	$0.30 m
Queensland	$0.41 m
Northern Territory	$0.62 m
South Australia	$0.41m
Western Australia	$0.32 m
Australian Capital Territory	Nil
Tasmania	Nil
TOTAL	**$2.53 m**

Additionally, the following funds are flowing to specific initiatives:

- $1 million over two years (2001-02 to 2002-03) under the COAG Diversion Initiative to petrol sniffing programs in Central Australia and the Top End of the Northern Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-005

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: EYE HEALTH/TRACHOMA

Hansard Page: CA 229

Senator Crowley asked:

Could you provide some detail about whether there are any funds provided for eye health going to education of the community as apart from educating the specialists or doctors?

Answer:

No funds are specifically allocated for community education under the National Aboriginal and Torres Strait Islander Eye Health Program. However, Regional Eye Health Coordinators employed under the Program have community education as one of their roles. In 2000/01 $2.1 million was expended on regional coordination.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-089

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: HEALTH STRATEGIES

Hansard Page: CA 235

Senator Crowley asked:

(a) Could the Department provide to the Committee whether there are any specific programs for rheumatic fever, streptococcal infection, infant mortality and SIDS?
(b) What Commonwealth health funds have been allocated to these programs?
(c) Are these funds directed specifically to a program or through a regional coordinated primary health or other kind of care arrangement?
(d) Is there any funding allocated to education about primary health issues in terms of prevention – early diet, hygiene et cetera?

Answer:

(a) The Commonwealth supports the enhancement of the comprehensive primary health care system to respond appropriately and adequately to early detection and treatment of rheumatic heart fever and disease, streptococcal infection, infant mortality and SIDS through the provision of funding to Aboriginal Community Controlled Health Services for comprehensive primary health care service delivery and infrastructure.

Additionally, the Department is committed to the implementation of the Primary Health Care Access Program (PHCAP). The PHCAP program aims to increase and enhance both the resources available for primary health care and the effectiveness of existing service delivery arrangements.

Rheumatic Fever/ Rheumatic Heart Disease
Since 1997 the Department has provided funding towards a Rheumatic Heart Disease Register in the Top End of the Northern Territory and in 2000 the Register was extended to Central Australia. The registry has had a key role in upgrading and maintaining the quality of treatment and management of Aboriginal children and young adults with rheumatic fever in the Northern Territory. Specifically, it allows the provision of penicillin prophylaxis to be targeted and maintained, enables education and counselling for patients and their families, and promotes awareness for the early detection and diagnosis of new cases of rheumatic fever.

Streptococcal Infection
The Office for Aboriginal and Torres Strait Islander Health collaborated with the Australasian Dermatological Research and Education Foundation and the National Aboriginal Community Controlled Health Organisation (NACCHO) in the production of *A Handbook of Skin Conditions in Aboriginal Populations of Australia* (Dr Alan Green, 2001). There has been a positive response to the Handbook from health professionals with over 1500 copies of the publication distributed to dermatologists, general practitioners and Aboriginal community controlled health services. The Handbook includes information to assist in the diagnosis of skin conditions relating to Streptococcal infection.

Infant Mortality
The evidence suggests that antenatal and related population health programs, provided as a component of comprehensive primary health care, can reduce complications of pregnancy, the incidence of low birth-weight and perinatal deaths. Given the unacceptably high rates of infant mortality and morbidity, the incidence of low birthweight and poor early growth in Indigenous babies and the short and long-term health implications of these factors, improving access to antenatal, maternal and child health programs is a high priority. Specific funding is therefore provided to Aboriginal Community Controlled Health Services for this purpose.

The National Childhood Immunisation Program is a preventive population health initiative managed by the Population Health Division (PHD) and provides (age appropriate) immunisation, in line with Australian Standard Vaccination Schedule (ASVS), for Aboriginal and Torres Strait Islander infants and children. This Program is delivered through public and private providers including Aboriginal Community Controlled Health Services (ACCHS). The National Childhood Pneumococcal Immunisation Program, launched in May 2001, is a specifically targeted program aimed at addressing the high rates of invasive pneumococcal disease among infants and children in Indigenous communities.

There are many examples of successful, locally initiated projects, which have effected an improvement in infant health outcomes. An example from the Northern Territory is the "*Strong Women Strong Babies Strong Culture Project*". The Project has had a measurable impact on infant mortality and morbidity rates and complements routine antenatal care delivered through community health centres across the Northern Territory.

Another example is the Ngaanyatjatjarra Pitjantjatjara Yankunytjatjara (NPY) Women's Council's " *Strong Women Strong Families/Nutrition Project for Mothers and Babies*". The project has evolved since its inception in 1996 to taking a comprehensive primary health care approach to nutrition and incorporating additional services around maternal and child health and child protection, involving clinical service delivery, case management, education and prevention. This project has also reported a decline in infant mortality and morbidity rates since its commencement.

SIDS

Knowledge of the risk factors for Sudden Infant Death Syndrome (SIDS) and their combined influences are still incomplete, particularly in relation to Aboriginal and Torres Strait Islander Australians. Generally, the number of cot deaths in Australia have drastically reduced over the last few years, primarily a result of increased public awareness due to successful parent and professional education campaigns. Such campaigns have not had the same impact on the rates of SIDS in Aboriginal and Torres Strait Islander communities. The NHMRC has therefore funded a number of research projects specifically and/or generally examining SIDS in Aboriginal and Torres Strait Islander populations.

The Department provides significant funding, matched by State and Territory health departments, for population health issues through the Public Health Outcome Funding Agreements (PHOFAs) this funding also support SIDS activities. For example, Stillborn and Neonatal Death Support (New South Wales), a charitable organisation associated with the NSW Sudden Infant Death Association previously applied for and received assistance from the State Government through similar funding mechanisms.

The Department is supportive of educational initiatives undertaken by SIDS Australia such as the information brochure for Indigenous women, "Taking Care of Your Baby" (2001).

The Department, together with the Department of Education Training and Youth Affairs (DETYA), Attorney General's Department and the Department of Family and Community Services, provide funding to the Telethon Institute for Child Health Research to conduct the "Western Australian Indigenous Child Health Survey". This project has surveyed households and schools to collect health information and data on Aboriginal children in Western Australia aged 0-17, and their families. The project commenced in 2000, and additional funding has been approved to enable the required sample survey target numbers to be achieved. Data has now been collected on approximately 4,000 children and is currently being analysed. This data may have general application.

The Kulunga Research Network, is in the early stages of developing a collaborative, maternal and child health research, information and training network involving the West Australian Institute of Child Health Research in Perth and member services of the West Australian Aboriginal Community Controlled Health Organisation (WAACCHO). The Network manages the *Bibbulung Gnarneep* - Building *Solid Kids Project* Project. The Project involves a study of a cohort of mothers during pregnancy and their babies during the first two years of life looking at SIDS risk factors and other defining health issues. A second phase involves home visiting to provide access to medical appointments and regular antenatal checks, information and education (reducing the risk of SIDS) and to provide cultural support and advocacy.

(b) Total expenditure on comprehensive primary health care services to Aboriginal and Torres Strait Islander communities was approximately $181.5 million in 2001-02, and $212.5 million has been allocated for 2002-03. The Primary Health Care Access Program (PHCAP) was announced in the 1999-2000 Budget, with funding of $78.8 million over four years. The 2001-02 Budget announced an additional $19.7 million each year from 2003-04, taking the total recurrent base for the program to $54.8 million per annum.

Total OATSIH contribution to the Telethon Institute for Child Health Research in 1999/2000, 2001/2002, 2002/2003 is $1,551,151 and to the Kalunga Research Network in 2001/02 and 2002/03 is $120,000.

Rheumatic Fever/ Rheumatic Heart Disease
In November 1997 the Department ($79,960) and the Australian Institute of Health and Welfare ($73,270) provided funding for the two-year establishment phase of a rheumatic heart disease control program in the Top End of the Northern Territory. In February 2000, the Commonwealth and the AIHW agreed to provide an additional $35,000 to extend the establishment phase of the program. In April 2002, the Commonwealth agreed to fund the Rheumatic Heart Disease Register an additional $255,000 over two years (12 months for the Top End and 24 months for Central Australia).

Streptococcal infection
In 2001-02 the Office for Aboriginal and Torres Strait Islander Health (OATSIH) contributed $60,000 towards the costs of editing and publishing the publication.

Infant mortality
The Office for Aboriginal and Torres Strait Islander Health (OATSIH) provides approximately $75,000 per year to the NPY Women's Council for their Nutrition Project for Mothers and Babies. The OATSIH's commitment to funding primary health care (outlined above) also contributes to addressing this issue.

SIDS
The Department continues to fund SIDS research through the National Health and Medical Research Council (NHMRC). In 2002, the NHMRC has directed nearly $2 million for research investigating the causes, risk factors and prevention strategies relating to peri-natal and infant death. A number of the research projects specifically or generally examine SIDS in relation to Aboriginal and Torres Strait Islander populations. The Kalunga Research Network (described above) is also addressing the issue of SIDS.

(c) The Department is further committed to the implementation of the Primary Health Care Access Program (PHCAP). The PHCAP program will establish a framework for the expansion of comprehensive primary health care services on a regional basis and enhance both the resources available for primary health care and the effectiveness of existing service delivery arrangements.

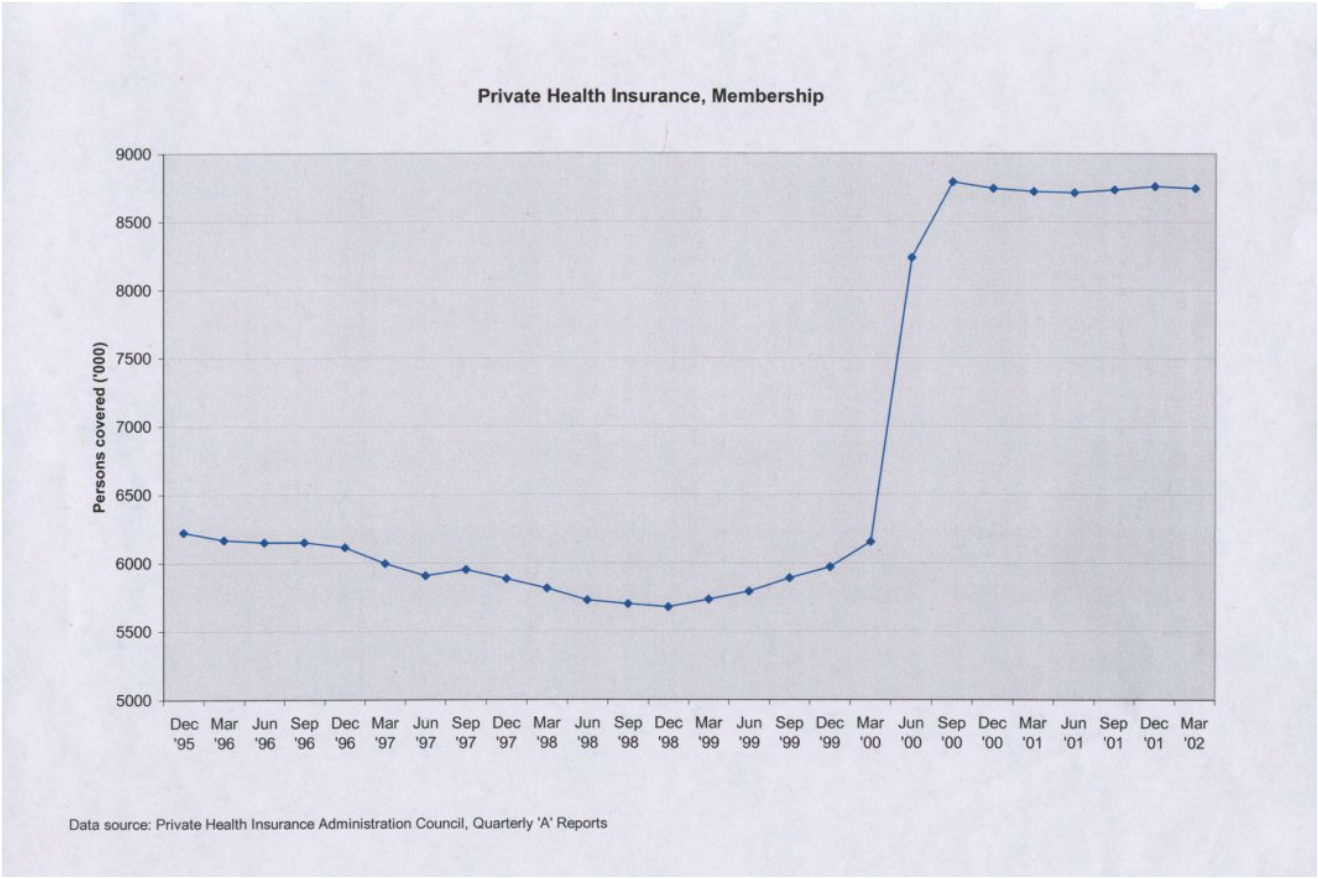
The Office for Aboriginal and Torres Strait Islander Health (OATSIH) is currently facilitating the development of an Aboriginal and Torres Strait Islander Maternal and Child Health Framework which will support the improvement of systemic responses to the holistic physical, emotional and social wellbeing of Aboriginal and Torres Strait Islander women and children to effect an improvement in health outcomes such as infant mortality.

The Department's Population Health Division (PHD) is currently in the process of developing a strategic approach to mainstream maternal and child health needs. The OATSIH Framework will be developed and implemented in complement with this initiative.

(d) Funding for comprehensive primary health care services (including the Primary Health Care Access Program) and the Dermatological Handbook initiative is provided through nationally and regional coordinated primary health care arrangements. Funding for specific initiatives such as the Rheumatic Heart Disease Register and the NPY Women's Council's Nutrition Project for Mothers and Babies is program specific.

Primary Prevention is an integral component of comprehensive primary health care and as such, is resourced through funding for comprehensive primary health care. In addition, the *National Child Nutrition Program,* managed by the Population Health Division, is a $15 million community grants program which aims to improve the diet and long term eating patterns of children aged 0-12 years and pregnant women. It particularly targets high need communities, including Aboriginal and Torres Strait Islander communities, socio-economically-disadvantaged groups and communities in rural and remote areas. The program is funding around 115 local community projects for up to three years. Over $4.6 million is funding projects specifically targeting Aboriginal and Torres Strait Islander communities. A number of these projects are supporting the National Indigenous English Literacy and Numeracy Strategy 2000-2004 and will operate in close cooperation with schools. The program targets community based projects which aim to: improve nutrition related knowledge and skills of children and their parents; the capacity of communities to promote better nutritional health; and access to and availability of nutritious foods.

The *National Aboriginal and Torres Strait Islander Nutrition Strategy and Action Plan 2000-2010* aims to facilitate a coordinated national approach to Indigenous public health nutrition through highlighting key areas for national action to improve Indigenous health and wellbeing through better nutrition. It forms an integral part of the broader public health nutrition strategic framework and agenda for action, *Eat Well Australia 2000-2010*, produced through the National Public Health Partnership's Strategic Inter-Governmental Nutrition Alliance. This strategy was endorsed at the Australian Health Ministers Conference on 1 August 2001 where it was agreed that jurisdictions would continue to work cooperatively through the National Public Health Partnership to invest in identified priority health gain areas.



Data source: Private Health Insurance Administration Council, Quarterly 'A' Reports

Lifetime Health Cover

Table 9.

Hospital Membership

Number of adult beneficiaries

Certified Age At Entry	31 March 2001			30 June 2001			30 September 2001			31 December 2001			31 March 2002			LHC Loading %
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	
30	2,913,205	3,258,148	6,171,353	2,906,812	3,254,681	6,161,493	2,901,894	3,251,502	6,153,396	2,898,467	3,246,844	6,145,311	2,893,650	3,248,614	6,142,264	0%
31	1,519	1,289	2,808	2,266	1,970	4,236	3,065	2,687	5,752	3,863	3,420	7,283	4,615	4,129	8,744	2%
32	1,200	1,043	2,243	1,865	1,575	3,440	2,516	2,158	4,674	3,114	2,806	5,920	3,705	3,312	7,017	4%
33	988	882	1,870	1,504	1,349	2,853	2,086	1,926	4,012	2,661	2,374	5,035	3,221	2,902	6,123	6%
34	957	815	1,772	1,434	1,270	2,704	1,940	1,716	3,656	2,418	2,141	4,559	2,835	2,560	5,395	8%
35	861	793	1,654	1,289	1,171	2,460	1,808	1,604	3,412	2,261	1,974	4,235	2,654	2,364	5,018	10%
36	791	769	1,560	1,181	1,102	2,283	1,657	1,556	3,213	2,031	1,954	3,985	2,410	2,282	4,692	12%
37	778	658	1,436	1,152	975	2,127	1,579	1,355	2,934	1,945	1,697	3,642	2,318	1,993	4,311	14%
38	728	679	1,407	1,042	1,023	2,065	1,400	1,378	2,778	1,790	1,736	3,526	2,135	2,027	4,162	16%
39	633	596	1,229	963	894	1,857	1,296	1,254	2,550	1,653	1,568	3,221	1,991	1,854	3,845	18%
40	647	603	1,250	906	859	1,765	1,254	1,172	2,426	1,572	1,479	3,051	1,896	1,745	3,641	20%
41	563	549	1,112	824	800	1,624	1,115	1,048	2,163	1,433	1,361	2,794	1,724	1,624	3,348	22%
42	514	486	1,000	756	737	1,493	1,049	1,028	2,077	1,300	1,307	2,607	1,539	1,543	3,082	24%
43	451	432	883	706	690	1,396	966	949	1,915	1,210	1,209	2,419	1,440	1,460	2,900	26%
44	441	445	886	657	657	1,314	909	877	1,786	1,180	1,095	2,275	1,402	1,293	2,695	28%
45	383	422	805	631	647	1,278	846	901	1,747	1,088	1,109	2,197	1,279	1,294	2,573	30%
46	374	387	761	556	591	1,147	775	761	1,536	989	998	1,987	1,159	1,245	2,404	32%
47	356	345	701	530	523	1,053	731	736	1,467	923	923	1,846	1,110	1,123	2,233	34%
48	331	347	678	522	526	1,048	682	711	1,393	848	874	1,722	1,024	1,024	2,048	36%
49	325	304	629	500	417	917	682	587	1,269	842	758	1,600	977	913	1,890	38%
50	272	272	544	388	412	800	532	610	1,142	650	757	1,407	817	844	1,661	40%
51	258	297	555	384	422	806	529	555	1,084	704	695	1,399	799	791	1,590	42%
52	274	247	521	408	356	764	511	501	1,012	640	615	1,255	751	750	1,501	44%
53	234	245	479	336	380	716	465	478	943	601	598	1,199	689	672	1,361	46%
54	212	218	430	309	323	632	451	453	904	571	569	1,140	657	662	1,319	48%
55	145	153	298	237	270	507	342	370	712	441	476	917	533	561	1,094	50%
56	169	163	332	244	243	487	319	328	647	396	415	811	473	508	981	52%
57	141	121	262	212	203	415	294	254	548	369	346	715	431	414	845	54%
58	113	115	228	176	176	352	240	236	476	319	302	621	356	356	712	56%
59	105	114	219	154	170	324	187	231	418	253	281	534	297	332	629	58%
60	101	108	209	151	152	303	189	214	403	253	268	521	302	325	627	60%
61	87	108	195	130	172	302	166	217	383	203	272	475	254	289	543	62%
62	73	111	184	113	158	271	165	224	389	219	299	518	263	315	578	64%
63	66	103	169	120	154	274	166	213	379	210	269	479	242	326	568	66%
64	64	89	153	91	152	243	122	188	310	160	239	399	193	306	499	68%
65	99	148	247	170	252	422	254	380	634	345	518	863	400	604	1,004	70%
Total	2,928,458	3,272,604	6,201,062	2,929,719	3,276,452	6,206,171	2,933,182	3,281,358	6,214,540	2,937,922	3,284,546	6,222,468	2,940,541	3,293,356	6,233,897	

Source: Private Health Insurance Administration Council

Recipients may freely use these statistics, however the source must be acknowledged.

The Federal Government 30% Rebate on private Health Insurance
Information for Tabling at Budget 2002-03 Budget Estimates Hearing 2002

Table 1: Variation between the Budget 2002-03 ($ million) from 2001-02 Additional Estimates

Year	2001-02 Additional Estimates	2002-03 Budget Estimates
2001-02	2,221	2,146
2002-03	2,314	2,276
2003-04	2,429	2,278
2004-05	2,550	2,280
2005-06	2,678	2,281

Table 2: Disaggregation of Total Cost of the 30% Rebate Excluding Premium Growth

	2001-02	2002-03	2003-04	2004-05	2005-06
Total estimated accrual	2,146	2,276	2,278	2,280	2,281
Accrual Revenue	183	186	186	186	186
Accrual Outlays	1,963	2,090	2,092	2,094	2,095

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-074

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: AGE BREAKDOWN OF PEOPLE PAYING LIFETIME HEALTHCOVER LOADING

Hansard Page: CA 240

Senator Evans asked:

(a) Do you have an age breakdown on people paying a loading under Lifetime Health Cover?
(b) Have we done any analysis of these figures?

Answer:

(a) Table outlining Lifetime Health Cover Hospital membership for the March Quarter of 2002 is attached (see Attachment 1).

(b) The Department has performed preliminary analyses of the figures up to the March Quarter 2002.

During this time more people joined in the younger age groups when the loading is less, and less people joined in the older age groups when the level of loading is increased by 2% for each year after 31 years (see Attachment 1).

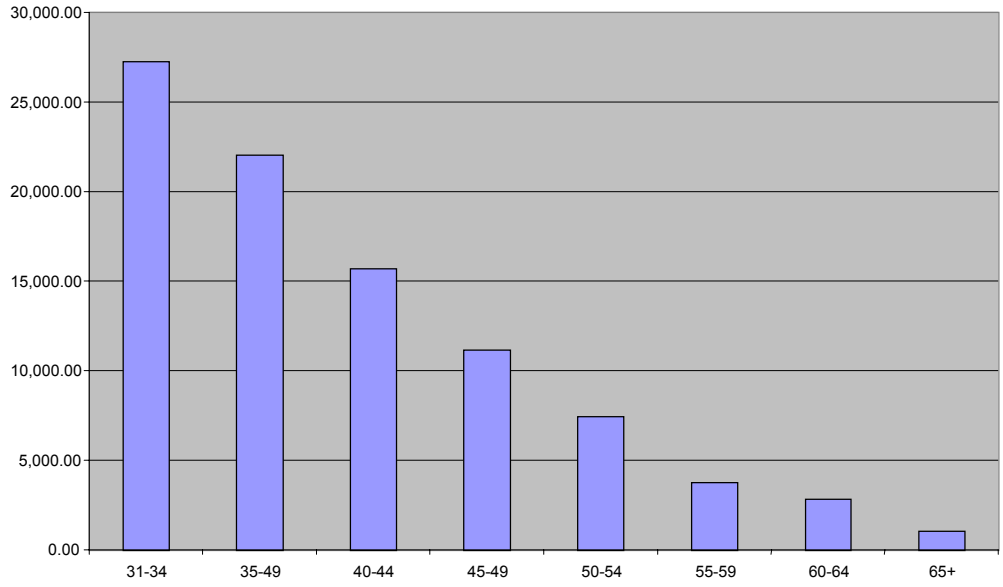
Attachment 1

Table 1: Lifetime Health Cover Hospital Membership, Number of Adult beneficiaries

Certified Age At Entry	Male	Female	Total
30	2,893,650	3,248,614	6,142,264
31	4,615	4,129	8,744
32	3,705	3,312	7,017
33	3,221	2,902	6,123
34	2,835	2,560	5,395
35	2,654	2,364	5,018
36	2,410	2,282	4,692
37	2,318	1,993	4,311
38	2,135	2,027	4,162
39	1,991	1,854	3,845
40	1,896	1,745	3,641
41	1,724	1,624	3,348
42	1,539	1,543	3,082
43	1,440	1,460	2,900
44	1,402	1,293	2,695
45	1,279	1,294	2,573
46	1,159	1,245	2,404
47	1,110	1,123	2,233
48	1,024	1,024	2,048
49	977	913	1,890
50	817	844	1,661
51	799	791	1,590
52	751	750	1,501
53	689	672	1,361
54	657	662	1,319
55	533	561	1,094
56	473	508	981
57	431	414	845
58	356	356	712
59	297	332	629
60	302	325	627
61	254	289	543
62	263	315	578
63	242	326	568
64	193	306	499
65	400	604	1,004
Total	**2,940,541**	**3,293,356**	**6,233,897**

Source: PHIAC Quarterly A Report – March Quarter 2002

Figure 1: Adult Beneficiaries by Five-Year Age Group



Source: PHIAC Quarterly A Report – March Quarter 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: E02-073

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: LIFESTYLE ANCILLARY PRODUCTS

Hansard Page: CA 243

Senator Crowley asked:

If you could provide us with a list of any other funds that have decided to now withdraw those products, the Committee would appreciate that.

And if there is a distinction between withdrawal of the entire product or a withdrawal of things that may be claimed within that product that would be helpful, because I think it would be sad if we were withdrawing all the fitness and lifestyle programs, if it is an encouragement for people to get better health.

Answer:

No fund this year, other than MBF, has withdrawn products from the range of lifestyle products for which it pays benefits.

One fund, NRMA Health Pty Ltd, has clarified that its lifestyle benefit limit per family is $200 per annum rather than $100 per person per annum.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-168

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH INSURANCE REVIEW

Written Question on Notice

Senator Evans asked:

We understand there is a review of PHI underway.
(a) When is this review due to report?
(b) What is the scope of this review?
(c) Who is conducting this review?
(d) What will follow from this review?

Answer:

(a) The review is due to report to the Minister by the middle of this year.

(b) The review will examine the regulatory framework within which health funds operate.

(c) The Department of Health and Ageing with assistance of an Inter-Departmental Committee including representatives of the Department of the Prime Minister and Cabinet, the Department of the Treasury, the Department of Finance and Administration and the Private Health Insurance Administration Council.

(d) This will be dependent on the specific outcomes of the review.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-169

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH COVER

Topic: PRIVATE HEALTH INSURANCE – ADVERTISING

Written Question on Notice

Senator Evans asked:

The Government has spent $5.5 million promoting the private health insurance rebate during the life of the previous parliament.

(a) How much money has been spent on advertising for private health insurance in the year 2001-02?
(b) How is the effectiveness of this advertising measured?
(c) Why does the Government do this advertising? Why is this not left to the health insurance industry?

Answer:

(a) In 2001, $9,630,893.41 was spent on production and placement of advertisements related to private health insurance: $8,727,460.89 was spent in financial year 2000-01; $903,432.52 was spent in financial year 2001-02.

(b) As is standard for all government communications, tracking of effectiveness of this advertising, including levels of awareness and understanding, was measured through market research and evaluation.

(c) The Government has a duty of care to ensure that Australians are informed in an unbiased way of changes to legislation that allowed for greater access to 'no or known gap' insurance. The Government also has a duty of care to ensure Australians know how to access these new arrangements. Health funds advertise their individual products.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-170

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH COVER

Topic: INCREASE IN PHI PREMIUMS

Written Question on Notice

Senator Evans asked:

Revisions to the 2002-03 estimates show that the Government planned for a 23.4% increase in health insurance premiums over 4 years 2000-01 to 2004-05.

Minister Patterson said this was partly due to people switching to a higher level of cover.

(a) What is the evidence for this?
(b) Did the Department provide a briefing to this effect?
(c) If premium prices increase, wouldn't this lead to people switching to cheaper levels of cover?

Answer:

(a) The question refers to information contained in forward estimates tabled at the Additional Estimates hearings on 20 Feb 2002. These estimates have subsequently been updated and revised figures were tabled at the Budget Estimates hearings on 5 June 2002. It is not the case that the increase in the estimates shown in the figures tabled in February is solely attributable to projected premium growth.

(b) Not applicable, please refer to the answer provided in part (a).

(c) Not applicable, please refer to the answer provided in part (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: E02-171

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: EFFECT OF THE MEDICAL INDEMNITY CRISIS

Written Question on Notice

Senator Evans asked:

Increasingly specialists and other healthcare providers such as midwives are only covered if they undertake services in public hospitals where the States are willing to provide medical indemnity cover.

(a) What effect is this having on the ability of patients with private cover to receive treatment?
(b) Does this mean that far, from easing the burden on public hospitals, private health insurance is contributing to the pressure for services?
(c) What will be done to address this?

Answer:

(a) The Commonwealth is not aware of any systemic problems in private patients' accessing private hospital services as a result of private practitioner medical indemnity issues. While the Commonwealth is aware that there have been some isolated instances in some specialities, such as obstetrics and gynaecology, where doctors have apparently limited services to private patients, the majority of private doctors appear to be continuing to provide private patient services.

(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: E02-172

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: EFFECT OF THE MEDICAL INDEMNITY CRISIS

Written Question on Notice

Senator Evans asked:

Private hospitals are finding it increasingly difficult to get affordable cover. Many private hospitals require doctors to have their own cover.

(a) Does the Government see this as a problem?
(b) What will be done to address this?

Answer:

(a) The Government is aware that some private hospitals are experiencing difficulties in securing affordable professional indemnity insurance.

(b) Issues relating to professional indemnity are being considered by Senator Coonan, Minister for Revenue and Assistant Treasurer. Senator Coonan has established processes with State and Territory Ministers and the Australian Local Government Association to address public liability issues more generally.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-173

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: COMPLAINTS TO THE PRIVATE HEALTH INSURANCE OMBUDSMAN

Written Question on Notice

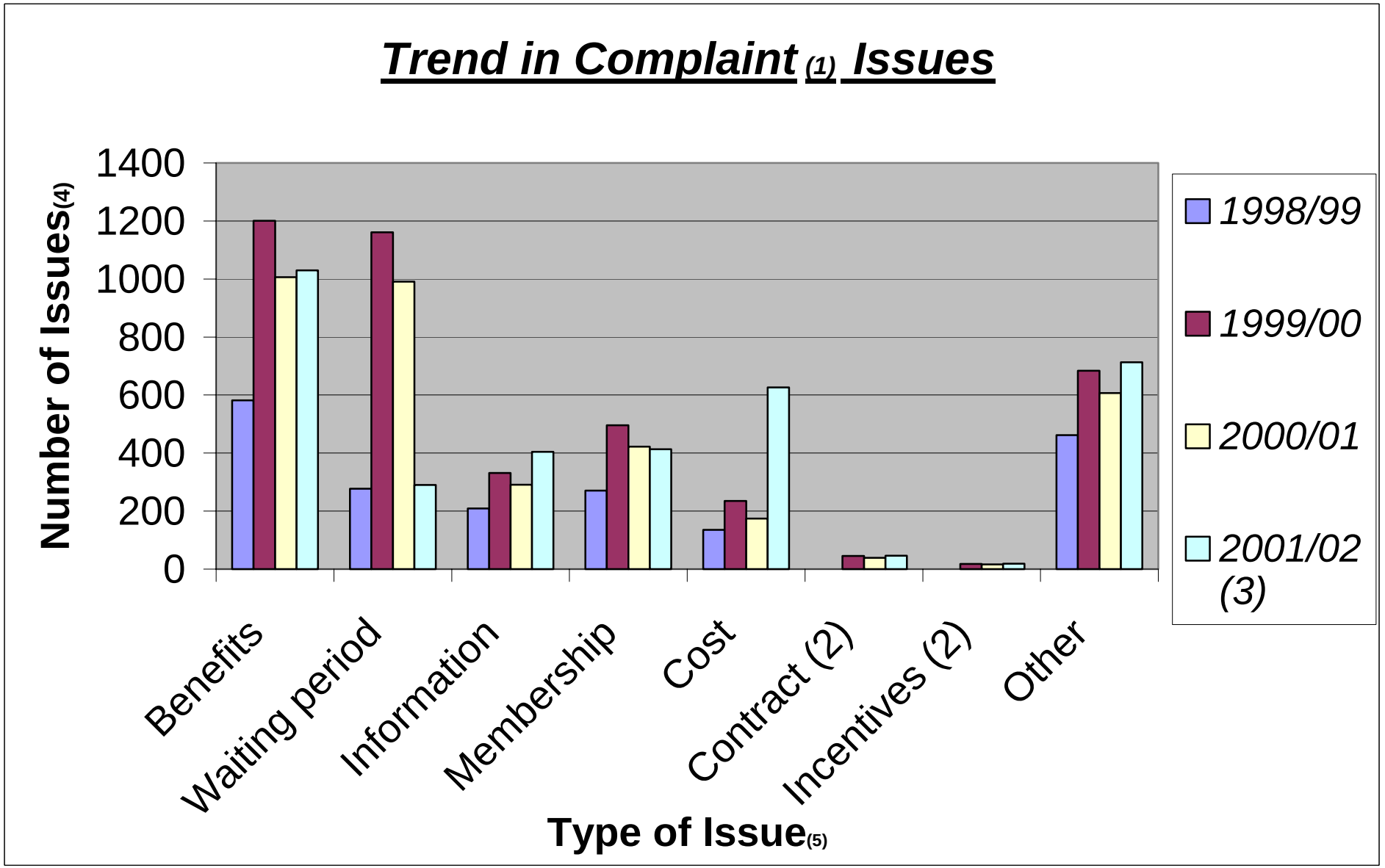
Senator Evans asked:

(a) What is the trend with complaint numbers and types?
(b) Please provide a list of complaints by year, fund and type for the years since and including 1999.

Answer:

(a) Please see attached graph entitled “Trend in Complaint Issues”.

(b) Please see attached table entitled “Health Fund Complaints 99-02”.



1. **Complaints = Problems, Grievances and Disputes**
2. **"Contract" and "Incentives" not separately recorded before 1999/00**
3. **2001/02 (3) represents complaints recorded up to 18 June 2002**
4. **A complaint may have more than one issue recorded for it (ie. one complainant may complain about "Benefit" and "Information)**
5. **List of Sub-issues provided next page.**

Matter Issues & Sub Issues

Benefit	Accident and Emergency
Benefit	Accrued
Benefit	Ambulance
Benefit	Amount
Benefit	Delay in Payment
Benefit	Excess
Benefit	Gap - Hospital
Benefit	Gap - Medical
Benefit	Level of Cover
Benefit	Limit Reached
Benefit	New Baby
Benefit	Non Acute Care
Benefit	Non Health Insurance
Benefit	Non Registered Practitioner
Benefit	Not in Private Practice
Benefit	Other Compensation
Benefit	Out of Pocket NEC
Benefit	Out of State
Benefit	Out of Time
Benefit	Prostheses
Benefit	Workers Compensation
Contract	2nd Tier Default Benefit
Contract	Code of Conduct Violations
Contract	Doctors & Dentists
Contract	Hospitals
Cost	Dual Charging
Cost	Fees / informed Financial Consent
Cost	Premiums
Incentives	Problems
Information	Lack of Notification
Information	Oral
Information	Printed
Information	Radio / Television
Information	Written
Membership	Arrears
Membership	Cancellation / Suspension
Membership	Non-Contributor
Membership	Transfer / Continuity
Membership	Young People
Other	Access
Other	Acute Care Certificates
Other	Complaint NEC
Other	Confidentiality
Other	Discrimination
Other	Fund Rule Change
Other	Premium Payment Problems
Other	Private Patient Election
Other	Service Issues
Waiting Period	Benefit Limitation Period
Waiting Period	General
Waiting Period	Obstetric
Waiting Period	Other
Waiting Period	Pre Existing Ailment

Complaints (Problems, Grievances and Disputes) by Health Fund(1)

Name of Fund	1998/1999		1999/2000		2000/2001		2001/02 *(2)	
	Complaints	% Market Share (3)	Complaints	% Market Share (4)	Complaints	% Market Share (5)	Complaints	% Market Share (6)
ACA Health Benefits Fund	0	0.1	0	0.1	2	0.1	1	0.1
AMA Health Fund Limited	0	0.1	1	0.1	0	0.1	0	0.1
Australian Health Management Group Limited	57	2.3	52	2.5	83	2.6	131	2.6
Australian Unity Health Limited	41	2.8	40	2.8	147	2.8	75	3.1
AXA Australia Health (National Mutual Health Insurance)	264	10.5	270	10.5	353	10.3	260	9.9
CBHS Friendly Society Limited	1	0.9	10	0.9	13	0.9	15	0.9
Cessnock District Health Benefits Fund	0	0	0	0	0	0	0	0
Credicare Health Fund (CUA Members Benefit Friendly Soc.)	10	0.5	9	0.5	6	0.5	8	0.4
Defence Health Benefits Society	22	1.2	21	1.2	37	1.1	28	1.1
Federation Health	0	0	0	0.1	3	0.2	9	0.2
Geelong Medical & Hospital Benefits Association Limited	4	1	8	1	19	1	15	1.2
Goldfields Medical Fund (Inc.)	1	0.2	1	0.2	18	0.5	322	0.7
Grand United Corporate Health Limited	7	0.3	11	0.3	8	0.2	7	0.2
Grand United Health Fund Pty Ltd	29	0.5	34	0.5	22	0.5	14	0.4
Health Care Insurance Limited	3	0.1	7	0.1	3	0.1	2	0.1
Health Insurance Fund of W.A.	2	0.3	11	0.3	11	0.4	11	0.4
Health-Partners Inc.	7	0.6	17	0.6	6	0.5	10	0.5
Healthguard Health Benefits Fund Limited	0	0.1	1	0.1	1	0.1	0	0.1
HBF Health Funds Inc.	58	11.4	48	11.4	90	8.9	90	8.8
Hospitals Contribution Fund of Australia Limited	98	8.4	128	8.4	144	7.8	112	7.3
IOOF Health Services Limited	3	0.2	3	0.2	15	0.2	7	0.2
I.O.R. Australia Pty Limited	10	0.7	21	0.7	47	0.2	76	1.1
Latrobe Health Services Inc.	8	0.4	5	0.4	9	0.5	6	0.5
Lysaght People Care (Lysaght Hospital and Medical Club)	1	0.2	0	0.2	1	0.2	0	0.2
Manchester Unity Friendly Society In N.S.W.	34	1	49	1	105	1.3	51	1.2
Medibank Private Limited	481	27.1	432	27.1	1075	29.7	986	30.7
Medical Benefits Fund of Australia Limited	419	18.2	396	18.2	671	17.3	506	16.9
Mildura District Hospital Fund Limited	1	0.3	2	0.3	1	0.3	0	0.3
Navy Health Limited	5	0.3	1	0.3	2	0.3	4	0.2
N.I.B. Health Funds Limited	84	4.6	106	4.6	152	5.4	140	4.9
NRMA Health Pty. Limited	n/a	n/a	n/a	n/a	34	1.5	28	1.5
Phoenix Welfare Association Limited	2	0.2	1	0.2	0	0.1	0	0.1
Queensland Country Health Limited	5	0.2	0	0	3	0.2	3	0.2
Railway & Transport Emp'ees Friendly Soc. H.F. Ltd.	7	0.4	8	0.4	4	0.3	5	0.3
Reserve Bank Health Society	0	0.1	1	0.1	0	0.1	0	0
SGIO	19	1.2	n/a	n/a	n/a	n/a	n/a	n/a
SA Police Employees' Health Fund Inc.	0	0.1	0	0.1	2	0.1	1	0.1
St Luke's Medical & Hospital Benefits Ass. Ltd.	12	0.5	9	0.5	6	0.4	12	0.4
Teachers Fed'on Health Limited (NSW Teachers Federation)	23	1.5	17	1.5	14	1.4	24	1.4
Transition Benefits Fund Pty Limited	1	0.2	1	0.2	0	0.1	0	0.1
Queensland Teachers' Union Health Fund Limited	2	0.4	11	0.4	8	0.4	7	0.4
Transport Friendly Society Limited	3	0.1	4	0.1	4	0.1	3	0.1
United Ancient Order of Druids Victoria	1	0.1	6	0.1	0	0.1	2	0.1
United Ancient Order of Druids G/L NSW	0	0.1	0	0.1	3	0	1	0
Western District Health Fund Ltd (westfund)	19	0.4	20	0.4	26	0.7	26	0.7
Yallourn Medical & Hospital Society	1	0.1	n/a	n/a	n/a	n/a	n/a	n/a
Total for Registered Funds	**1745**		**1762**		**3148**		**2998**	

1. **Total Complaints registered, by health fund membership.**
2. **2001/02 complaint registered from 1 July 2001 to 18 June 2002**
3. **Derived from 1998 PHAC Annual Report**
4. **Derived from 1999 PHIAC Annual Report**
5. **Derived from 2000 PHIAC Annual Report**
6. **Derived from 2001 PHIAC Annual 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: E02-177

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SALE OF MEDIBANK PRIVATE

Written Question on Notice

Senator Evans asked:

This year Medibank Private requested permission to raise its premiums by 13%. The Government allowed a premium rise of 9%.

(a) On what basis was this request granted?
(b) Why was the full request not granted?

Answer:

(a) As confirmed by Mr Peter Young of Medibank Private at the Budget Estimates hearings on 5 June 2002 (Hansard Page CA253), Medibank Private Limited applied to increase premiums at the start of this year. Mr Young advised the Committee that Medibank Private considers premium increase applications to be commercial-in-confidence.

(b) All requests for premium changes are considered in accordance with statutory requirements. The Minister is empowered under subsection 78(4) of *the National Health Act 1953* (the Act) to declare that a premium change shall not come into operation if she is of the opinion that the change:
- would or might result in a breach of the Act or of a condition of registration of an organisation;
- imposes an unreasonable or inequitable condition affecting the rights of any contributors; or
- might, having regard to the advice of the Private Health Insurance Administration Council (PHIAC), adversely affect the financial stability of a health benefits fund.

The Minister is also empowered under subsection 78(4A) of the Act to declare that a premium increase shall not come into operation of she is of the opinion that the increase would be contrary to the public interest.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-178

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SALE OF MEDIBANK PRIVATE

Written Question on Notice

Senator Evans asked:

There is some evidence that Medibank Private has gained market share by undercutting the prices of competitors. Is this the case? Has this affected the profitability of Medibank Private?

Answer:

Medibank Private has over 26 years traditionally been a low-margin, value-for-money PHI fund.

Medibank Private is a national health fund, and as such, undertakes marketing campaigns from time to time in order to attract new members and strengthen a national membership base.

During the introduction of Lifetime Health Cover, Medibank Private sought to price products that offered value for money and would appeal to people coming into the market for the first time. Medibank Private's products were priced profitably and were sold at a profit for quite a significant time. Accordingly, Medibank Private had strong operating results in the financial years ending June 2000 and June 2001, while offering competitive, affordable rates to the public.

Over the past 4 years Medibank Private has generated surpluses totalling $267 million (21% of industry surplus over that period) building its reserves to a record level of $557.9 million at 30 June 2001.

Medibank Private obtained 44% of the growth in private health insurance brought on by the introduction of Lifetime Health Cover.

The average age of Medibank Private members fell as a consequence of the introduction of Lifetime Health Cover. In 1999, 15.3% of Medibank Private's membership were aged 65 and over, compared to 10.8% in December 2001. Due to the impact of Lifetime Health Cover, the average age of Medibank Private's membership has fallen to 37.6 years, which is on par with the industry average of 37.7 years.

Today, Medibank Private holds 30.7% of national market share. Medibank Private remains the market leader in three states, NSW, Victoria and Queensland, in addition to the Northern Territory.

Medibank is now operating in a difficult business environment, having experienced higher than expected claims and higher than expected payments per claim. It has also undergone a decline in investment income.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-03, 5 & 6 June 2002

Question: E02-180

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: SALE OF MEDIBANK PRIVATE

Written Question on Notice

Senator Evans asked:

(a) Why has Medibank Private headquarters moved to Melbourne?
(b) What is the cost of the move?

Answer:

(a) As stated in the February 2002 Senate Estimates, Medibank Private has for the past 4 years since separation from the HIC, continuously reviewed the structure and location of all its major activities. The decision to move Medibank Private's Corporate Office from Canberra to Melbourne was made to improve the overall efficiency and competitiveness of the company.

A number of factors were considered when making the decision to close the Canberra office including the ongoing financial impact. There is an estimated saving of $891,830 per annum generated through reduced travel, accommodation and office accommodation costs.

Further, the equivalent rental per square metre in Canberra was $338, in comparison to current facilities in Melbourne being $281.

Any one-off relocation costs need to be offset against the long term savings.

The closure of the Canberra office did not effect Canberra retail centres, which have continued operating as normal.

(b) There has been a total of 21 redundancy payments made to Canberra based staff over the past two years totalling $1,193,505 (this excludes costs incurred as a result of the Medibank Private business decision to outsource IT).

At the February 2002 Senate Estimates, Medibank Private anticipated that the total cost of redundancies would cost $2.5 million. As at June 2002 the current estimate is $2.918 million. This cost includes the cost of redundancy and transitioning allowances, recruitment, relocation, project management, lease break and fit-out write off costs.

Through the transition period from Canberra to Melbourne, few additional staff (duplicated) employees have been required, with the exception of 4 individuals at a total estimated cost of $81,000. However, it is noted that the overall business of Medibank Private has expanded to meet the growth experienced from Lifetime Health Cover.

None of the Canberra based executives chose to relocate to Melbourne, therefore Medibank Private has not incurred any associated relocation costs.

NHMRC
National Health & Medical Research Council

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Dr George Stone
Chief, Extramural Inventions and Technology Resources Branch
Office of Extramural Research,
National Institutes of Health,
6705 Rockledge Drive MSC 7980
Bethesda, MD 20892-7980
USA

Dear Dr Stone

I am writing to you regarding the National Institute of Health proposed policy change, set out in Notice NO- OD -02 –239. The notice was posted on the NIH website on 14 March 2002, but has only recently come to my attention.

I understand that the proposed change will limit patent rights and ownership of intellectual property (IP) generated from NIH supported research by foreign grantees, with the aim of maximising the benefit of NIH funded research to the health and wealth of the U.S. and its citizens. Should this policy be implemented it will have a major, adverse, impact on the intellectual property rights of inventions made by foreign entities with NIH support. I am therefore requesting that the policy be reconsidered.

The issue of national benefit of public investment in research is undoubtedly one of the challenges that public research funding agencies around the world are currently facing. While the NHMRC can understand the motive behind the proposed change in policy, we are concerned that vesting intellectual property in a research funding organisation (as opposed to in a publicly funded research institution) is almost certain to severely hamper the positive exploitation of intellectual property. Indeed, I understand the Bayh-Dole Act in 1980 was enacted specifically in recognition of this principle.

The NHMRC is the Australian equivalent of the NIH. The NHMRC does not claim any ownership and/or associated IP rights derived from the research it supports in Australia. We have reached this conclusion following a substantial review of vesting of IP arrangements in Australian research institutions over the last 18 months, and place great emphasis on ensuring “public good” benefits flow from the research we fund.

Consequently, the NHMRC's *Interim Guidelines for Intellectual Property Management for Health and Medical Research*[1] vest ownership of IP with our administering institutions (all of which are located in the public or not for profit sectors, but are encouraged to develop links with commercial partners where appropriate). The *Interim Guidelines* (adherence with which will become a requirement for NHMRC funding in the near future) are not prescriptive but focus on fair recognition of all stakeholders in the research, and require institutions have in place an IP policy that includes the "method by which income from the development and exploitation of the IP will be allocated to inventors and other stakeholders".

In relation to the proposed NIH policy on IP, the NHMRC is of the view that the multi-faceted nature of research development and research infrastructure makes the task of attributing IP to any single funding agency extremely complex. Indeed the application of the NIH's proposed policy may well have the unintended consequence of capturing IP benefits of research funded by the NHMRC of Australia. This is because NIH is not necessarily the sole funder of major research programs in this country. It is for this reason that the NHMRC has a very strong interest in requesting that the NIH policy be amended, so that it equitably recognises all interests.

The NHMRC is also concerned that Australia may be relatively more disadvantaged than larger nations with collaborative research arrangements with the NIH. The proposed policy states, "*When implemented the policy will provide for foreign entity to retain the right to elect to retain the title to their Subject Invention in their country, while the NIH will have the right to the entire right, title and interest in all other countries*." For nations with large markets ready to invest in developing IP this may not be overly restrictive (countries such as Japan may of course have a different view), but in the Australian context this will almost inevitably lead to non-development of Australian inventions within Australia.

As you will surely agree, health and medical research collaborations between US and Australian researchers and industries have been very fruitful, in terms of delivering health returns as well as economic benefit to both countries. I believe it is in our shared interest to continue our support for such collaborations. Indeed there is a very high level of concern in the NHMRC and more broadly in the Australian research community that should the proposed policy be implemented by the NIH it will act as a substantial disincentive to future international collaborations.

I note that the proposed policy, as set out in Notice NO- OD -02 –239, provides the US government with the right and title to any patents generated by foreign grantees outside of the grantees' home country, but also states "…*This deviation from standard patent rights policy does not preclude foreign entities from requesting greater rights on a case-by-case basis*….". Negotiation of IP on an individual grantee basis would appear to be an extremely inefficient way to proceed and it is our firm view, in the interests of both transparency and equity, that IP policy should be common across all recipients of NIH funds.

As the Australian counterpart of the NIH, the NHMRC is the appropriate body with which to liaise and discuss the implications of the proposed change to the NIH's IP policy. The outcome of such discussions, should be agreement on mechanisms to ensure that the value and coverage of health related IP is maximised for widest possible benefit, whilst at the same time ensuring that collaborations between our health and medical researchers are not discouraged, and the contributions to the health and wealth of our citizens by our researchers is maximised.

[1] Interim Guidelines for Intellectual Property Management for Health and Medical Research, NHMRC 2001 http://www.nhmrc.gov.au/research/generalinfo.htm

I look forward to hearing from you.

Yours sincerely

Professor Alan Pettigrew
Chief Executive Officer
June 2002

CC Senator the Hon Kay Patterson, Minister for Health and Ageing
the Hon Dr Brendan Nelson MP, Minister for Education, Science and Training
the Hon Mr Peter McGauran MP, Minister for Science
The Hon Mark Vaile MP, Minister for Trade
Professor Nicholas Saunders, Chairman, NHMRC
Professor Warwick Anderson, Chairman, Research Committee, NHMRC
The Australian Research Council
The Australian Vice-Chancellors' Committee
Australian Academy of Science

NHMRC Funding for Research into Chronic Fatigue Syndrome: 1995 - 2002

The success rate for proposals relating to chronic fatigue syndrome research is in line with that of other fields. NHMRC funding is very competitive with less than 25% of applications for funding to the NHMRC being successful. Between 1995 and 2002 approximately ten applications were received by the NHMRC for funding of CFS research. Of these, three have been funded (slightly greater than the success rate for other research fields).

Of applications in the 2000 Round (for funding in 2001), two were successful:

- a grant of $500,000 over five years for a prospective study of the psychiatric and medical characteristics of post-infective fatigue and CFS, and
- a grant of $360,000 over three years to study the microbiological and immunological determinants of prolonged illness following Q fever. The aim of the latter project is to examine whether some chronic fatigue states result directly from infective illnesses.

In 2001, one application into chronic fatigue syndrome was submitted in NHMRC's annual project grant round. The application was not successful.

In 2002, three applications into chronic fatigue syndrome have been submitted in NHMRC's annual grant round. Following assessment by peer review the results of all project grant applications will be announced in early November 2002 for funding to commence in January 2003.

National Health and Medical Research Council

Media Release

25 April 2002 NHMRC Concern over Allegations of Scientific Misconduct

The National Health and Medical Research Council (NHMRC) has written to the University of New South Wales, expressing its concern over recent allegations of scientific misconduct and mismanagement of grant funds by one of its researchers.

The Executive Head of the Centre for Research Management, Ms Suzanne Northcott, said the allegations were serious and the Council was requesting, as a matter of urgency, all relevant reports undertaken by the University.

"We are also seeking advice on the anticipated independent external inquiry, particularly its membership, scope and timetable," Ms Northcott said.

"The NHMRC as Australia's principal funder of health and medical research, regards complaints relating to scientific misconduct and the proper management of grant funds extremely seriously and believes such allegations have the potential to damage the reputation of Australian science and its research institutions.

"The NHMRC has strict rules in regards to the use of its grant money. The Deed of Agreement between the Commonwealth and administering institutions clearly states that the grant can be terminated or suspended if: *The Commonwealth is reasonably satisfied that any statement made in the Application is incorrect or incomplete in a way which would have affected the original decision to approve the Grant*.

"The Deed also gives the Commonwealth the power to inspect and audit any documents relating to the expenditure by the Institution of the whole or any part of the grant, and the power to recover all monies not spent in accordance with the Deed," she explained.

"As a result, it is imperative that the NHMRC receive all relevant reports and advice on the matter of the independent external inquiry as soon as possible," Ms Northcott said.

NHMRC Media Contact:

For more information or comment from Ms Northcott, please contact Jeanne Klener on (02) 6289 5796 or 0401 995 534

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-181

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC RESPONSIBILITIES FOR REGULATION OF EMBRYO RESEARCH

Written Question on Notice

Senator Evans asked:

The NHMRC is to have a series of new responsibilities under the proposed legislative and regulatory framework for stem cell research.

(a) What additional resources (dollars and people) will be required by the NH&MRC for these tasks?
(b) What additional resources will be provided to the NH&MRC?

Answer:

The NHMRC is currently working through these issues, including discussing relevant matters with the Department of Finance.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-182

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC RESPONSIBILITIES FOR STEM CELL

Written Question on Notice

Senator Evans asked:

It is important that the public is provided with educational materials that explain the issues around new technologies such as stem cell research so that they are able to make informed decisions.

(a) What role can the NHMRC (through AHEC) play in this regard?
(b) What resources are available to AHEC to enable it to involved and educate the public in these issues?

Answer:

This question was responded to at the Budget Estimates 2002-2003 Hearings on 5 June 2002, please refer to Hansard page CA 266.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-183

OUTCOME 9: HEALTH INVESTMENT

Topic: AIHW DATA COLLECTION – DENTAL HEALTH

Written Question on Notice

Senator Evans asked:

According to information posted on the website of the AIHW's Dental Statistics and Research Unit, it appears that no new data has been collected through the National Dental Telephone Interview Surveys since 1996.

(a) Is this correct?
(b) If so, what is the explanation for this?
(c) Is dental health not seen as an important part of health?
(d) Is the availability of dental care to all Australians not seen as important to overall healthcare?

Answer:

(a-b) No it is not correct. The AIHW Dental Statistics and Research Unit did conduct a National Telephone Interview Survey in 1999 and will conduct a further Survey in the next few months. Although some information on the website had not been updated to include that information, two publications from the 1999 Survey have been available there for some time.

These publications include *Oral health and access to dental care 1994-96 and 1999* and *Rural oral health and access to dental care 1994-96 and 1999.*

The technical report from the Survey is now available on the website.

(c-d) Oral health is an important part of overall health of Australians. The information and description in *Australia's Health 2002* makes this clear.

The Australian Health Ministers' Advisory Council has released the document *Oral health of Australians: National planning for oral health improvement*, which describes future strategies in this field.

The National Health and Medical Research Council (NHMRC) Strategic Research Development Committee has identified oral health as a research priority. Professor Alan Pettigrew, the CEO of the NHMRC, recently announced that funding of $1.8 million has been allocated to 18 research projects concerned with oral health.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-006

OUTCOME 9: HEALTH INVESTMENT

Topic: CONSULTATIONS ON DRAFT LEGISLATION TO BAN HUMAN CLONING

Written Question on Notice

Senator Harradine asked:

(a) Could the Department provide a list of individuals and groups including representatives/experts in ART, medical research, consumer issues, ethics and law invited to attend consultations on draft legislation to ban human cloning and other unacceptable practices and to regulate certain research involving excess embryos?
(b) What is the process for selecting those to take part in the presentations?
(c) Were selections made from a larger list of all who may have an interest in participating?
(d) How were determinations made as to the length of time each party would be given to contribute their views on the draft legislation?

Answer:

(a) As requested, a list of individuals/groups invited to attend consultations on the draft Human Cloning and Research Involving Embryos Bill 2002 is included at Attachment A.

(b) Nominations for the national consultations were sought from each State and Territory Government, key Commonwealth Government agencies and the Prime Minister's Office. Nominations were collated by the NHMRC in consultation with each jurisdiction.

A letter of invitation from the Chief Executive Officer of the NHMRC, Professor Alan Pettigrew, was sent to each consultation nominee outlining the details of the scheduled consultation session.

Nominees were also encouraged to provide a written submission in support of their attendance/non-attendance at the specified consultation session.

(c) No – all names put forward by State and Territory Governments, key Commonwealth agencies and the Prime Minister’s Office were included in the consultations.

(d) Due to the timeframes imposed by the Council of Australian Governments for the development of this legislation, it was not possible to spend more than one day in each State and Territory. Grouping individuals with particular expertise was essential given the time available and the number of nominations. Sessions in each city were organised to ensure adequate time was scheduled to hear the views of all nominees from that jurisdiction. However, key nominees (a balance of scientists and ethicists) were invited to consultations individually. At the conclusion of each session nominees were encouraged to provide a written submission if they did not feel that there was adequate time to raise all of their issues.

State	Title	Name	Surname	Organisation	Represented by
ACT	Ms	Sue	Serjeanston	Academy of Science	
	Ms	Trish	Nicholls	Academy of Science	
	Dr	Thomas	Faunce	Health Law and Ethics Australian National University	
	Prof	Judy	Whitworth	John Curtin School of Medical Research	Dr Klaus Matthaei
	Dr	Klaus	Matthaei	John Curtin School of Medical Research	Prof Judy Whitworth
	Dr	Peter	McCullagh		
	Mr	Garry	Mayo	Australian National University School of Botany & Zoology Institutional Bio Safety Committee	
	Ms	Elizabeth	Grant	Department of Health Housing and Community Care	
	Mr	Phillip	Board	John Curtin School of Medical Research Institutional Bio Safety Committee	
	Mr	Chris	Copeland	Canberra Fertility Centre John James Memorial Hospital	
	Ms	Jane	Harrison	Family Planning Association ACT Inc	
	Dr	Martin	Stafford-Bell		
	Dr	Paul	Dugdale	ACT Department of Heath & Community Care	
	Mr	Glenn	Rees	Alzheimer's Association of Australia Inc	Ms Anne Eayrs
	Ms	Anne	Eayrs	Alzheimer's Association of Australia Inc	
	Mr	Stephen	Crocker	Diabetes Australia (ACT)	
	Mr	Frank	Cranston	Parkinson's Australian Capital Territory Inc	Mr Dennis Smith
	Ms	Prue	Borrman	President of the Health Care Consumers Association	
	Prof	John	Hearn	Australian National University Research	
	Ms	Mary	Joseph	ACT Right to Life Association	Mrs Kath Wolf
	Mrs	Kath	Wolf	ACT Right to Life Association	
	Bishop	George	Browning	Anglican Diocese of Canberra & Goulburn	
	Dr	Warwick	Neville	Australian Catholic Bishops Conference	
	The Rev'd Dr	Thorwald	Lorenzen	Canberra Baptist Churches	
	Most Rev'd	Francis P	Carroll	Catholic Archdiocese of Canberra and	Dr Warwick Neville

				Goulburn	
	Mrs	Mary	Uhlmann	Catholic Womens League Australia Inc	
	The Rev'd	Joy	Bartholomew	Presbyterian Church	
NSW	Dr	Robert	Loblay	Central Sydney Area Health Service Ethic Committee	
	Prof	Peter	Rowe	Children's Medical Research Institute	
	Prof	John	Shine	Garvan Institute of Medical Research	
	Prof	Rob	Sutherland	Garvan Institute of Medical Research Cancer Research Program	
	Prof	John	Rostas	Hunter Medical Research Institute	
	Prof	Denis	Wade	Johnson & Johnson Pty Ltd Pharmaceutical Research	
	Prof	Susan	Pond	Johnson & Johnson Pty Ltd Pharmaceutical Research	
	Dr	Paul	Brock	Motor Neurone Disease Association of NSW	
	Prof	Bernie	Tuch	Prince of Wales Hospital - Diabetes Transplant Unit	
	Prof	Peter	Gunning	Westmead Children's Hospital Division of Research	
	Prof	Rick	Kefford	Westmead Institute for Cancer Research	
	Prof	Tony	Cunningham	Westmead Millennium Institute	
	Dr	Scott	Giltrap	Albury Reproductive Medicine Centre	
	Dr	Geoff	Driscoll	City West IVF	
	Dr	Anne	Clarke	Fertility First - Hurstville Community Private Hospital	
	Dr	Graham	Hughes	IVF East - Prince of Wales Private Hospital	
	Dr	Trevor	Johnson	IVF NSW (Bondi Junction)	Dr Kevin Coetzee
	Dr	Kevin	Coetzee	IVF NSW (Bondi Junction)	
	Prof	Michael	Chapman	IVF South - St George Private Hospital	
	Dr	Malcolm	Tucker	North Shore Fertility (Gosford)	
	Prof	Douglas	Saunders	Northshore Fertility	
	Dr	David	MacCourt	St George IVF Fertility and Clinic	Anne Clarke

	Prof	Robert	Jansen	Sydney IVF	
	Dr	Robert	Woolcott	Sydney IVF (Newcastle)	
	Prof	Ian	Fraser	Sydney IVF (Public Clinic - RPA) Department of Gynaecology & Obstetrics	
	Prof	Peter	Illingworth	Westmead Fertility Clinic - Westmead Hospital	
	Ms	Sandra	Dill	Access Group	
	Mr	Bob	Turner	Australasian Spinal Research Trust	
		The Manager		Australian Society for Medical Research	
	Ms	Liz	Peers	Diabetes Australia (NSW)	
	Ms	Caroline	Lorbach	Donor Conception Support Group	
	Ms	Rowena	Newcomen	Juvenile Diabetes Research Foundation	
	Ms	Miriam	Dixon	Parkinson's (NSW) Inc - Concorde Hospital	
	The Most Rev'd Dr	Peter	Jensen	Anglican Diocese of Sydney	Accompanied by Ms Karin Sowada
	The Most Rev'd Dr	George	Pell	Catholic Archdiocese of Sydney	Dr Warwick Neville
		The Office Manager		The Australian Federation of Islamic Councils Inc	
	Rev Prof	James	Haire	Uniting Church in Australia	
NT	Ms	Rachel	Shanahan	NT Department of Chief Minister	
	Mr	Jeremy	Kirby	NT Department of Health & Community Services	
	Ms	Sue	Oliver	NT Department of Justice - Policy Section	
	Ms	Gale	Jamieson		
	Ms	Marianne	Fitch	Alzheimers Planning Welfare Assocation of NT	
	Ms	Linda	Rennie	Diabetes Australia Northern Territory	
	Ms	Jenny	Abdilla	Menzies School of Health Research - HREC	
	Dr	David	Brewster	Menzies School of Health Research - HREC	
	Dr	Shelley	Walton	Menzies School of Health Research - HREC	
	Ms	Jill	Huck	Menzies School of Health Research Joint IEC of DHCS	
	Prof	Charles	Webb	Pro Vice-Chancellor (Higher Education & Research)	

				Northern Territory University	
	Dr	Phillipa	Cutten	Reproductive Medical Unit	
	Ms	Reina	Flynn	Reproductive Medical Unit	
	Dr	David	Gawler	Royal Darwin Hospital	
	Dr	Philip	Nitschke		
	The Rt Rev'd	Phillip	Freier	Anglican Diocese of the Northern Territory	
	Most Rev'd	Edward	Collins	Bishop of Darwin	
	Mr	Trevor	Robertson	Buddhist Society of Northern Territory Incorporated	
	Ms	Robyn	Wardle	Family Planning Welfare Association of NT	
	Father	Joel	Xanthos	Greek Orthodox Chruch	
	Imam	Adama	Konda	Islamic Centre and Mosque	
	Mr	Tom	Kiely	Right to Life (NT)	
	Dr	David	Gawler	Royal Darwin Hospital	
	Major	Kelvin	Merrett	Salvation Army	
	Pastor	Richard	Felkel	Seventh Day Adventist Church	
	Rev Dr	Richard	Wallace	The Uniting Church in Australia	
	Ms	Isobel	Gawler	Women's Action Alliance	
	Prof	Kerin	O'Dea	Menzies School of Health Research	
Qld	Dr	Ken	Reed	Benitec Aust Ltd	
	Prof	Peter	Andrews	Institute of Molecular Bioscience	
	Prof	Wayne	Hall	Institute of Molecular Bioscience	
	Prof	Michael	Good	Queensland Institute of Medical Research	
	Prof	John	Mattick	University of Queensland Institute of Molecular Bioscience	Dr Melissa Little
	Dr	Melissa	Little	University of Queensland Institute of Molecular Bioscience	
	Dr	David	Molloy	IVF Directors Group - Fertility Society of Australia	
	Dr	Keith	Harrison	Queensland Fertility Group	
	Dr	John	Allan	Wesley IVF Services	
	Sister	Mary Regis	Dunne	Mater Private Hospital (QHEAC)	

	Dr	Astrid	Gesche	Queensland University of Technology Centre for the Study of Ethics	
	Mr	Michael	Barnes	Queensland University of Technology School of Justice Studies	
	The Most Rev'd Dr	Phillip	Aspinall	Anglican Diocese of Brisbane	
	Archbishop	John	Bathersby	Catholic Archdiocese of Brisbane	Ray Campbell
	Rev'd	Tim	Jaensch	Lutheran Church	Ms Inari Theil
	Ms	Inari	Thiel	Lutheran Church	
	Mr	Ray	Campbell	Queensland Bioethics Centre	
	Rev	Marjorie	Neil	Queensland Synod Bioethics Committee	
	Rev'd Dr	Ray	Reddicliffe	Uniting Church in Australia - Queensland Synod	Rev Marjorie Neil
	Dr	D	Killer	HREC Wesley Hospital	
	Dr	Grant	Cameron	The Prince Charles Hospital (HREC)	
SA	Rev Dr	Andrew	Dutney	SA Council on Reproductive Technology	
	Dr	Peter	Woolcock	SA Council on Reproductive Technology	
	Dr	Christine	Kirby	SA Council on Reproductive Technology	
	Ms	Lindsay	Smith	SA Council on Reproductive Technology	
	Ms	Su	Cox	SACRT	
	Ms	Sheryl	de Lacey	SACRT	
	Dr	Christopher	Juttner	BresaGen Limited	
	Dr	Meera	Verma	BresaGen Limited	
	Ms	Jackie	Zanetti	BresaGen Limited	
	Dr	Allan	Robins	BresaGen Limited	
	Dr	Al	Vedig	Human Research Ethics Committee Flinders Medical Centre - Flinders University	
	Dr	Mark	Hoby	Human Research Ethics Committee North Western Adelaide Health Service	
	Dr	Ross	Haslam	Human Research Ethics Committee Women and Children's Hospital	Dr Peter Baghurst
	Dr	Jan	Liebelt	Human Research Ethics Committee Womens and Childrens Hospital	

	Dr	Peter	Baghurst	Human Research Ethics Committee Women and Children's Hospital	Ross Haslam
	Rev	Carl	Aiken	Research Ethics Committee Womens and Childrens Hospital	
	A/Prof	Eric	Haan		
	Prof	Robert	Norman	University Deptartment of Obstetrics & Gynaecology Queen Elizabeth Hospital - Reproductive Medical Unit	
	Dr	Jeremy	Thompson	University Deptartment of Obstetrics & Gynaecology Queen Elizabeth Hospital - Reproductive Medical Unit	
	Dr	John	Fleming	Southern Cross Bioethics Institute	
	Dr	Brian	Stoffell	Medical Ethics Unit	
Tas	Prof	Don	Chalmers	Law School - University of Tasmania	Ms Diane Nicols
	Ms	Diane	Nicols	Law School - University of Tasmania	
	Prof	Terry	Dwyer	Menzies Centre	
	Rev	Val	Graydon	Tasmanian Council of Churches	
	Dr	Bill	Watkins	Tasmania IVF	
	Dr	Christopher	Newell	School of Medicine - University of Tasmania	
	Ms	Robyn	Wilkinson	Tasmanians for Disabilities	
Vic	Dr	Peter	Mountford	Stem Cell Sciences	
	Dr	Nicholas	Tonti-Filipini	Catholic Church	
	Dr	Annabelle	Duncan	CSIRO Molecular Science	
	Ms	Catriona	King	ES Cell International	
	Mr	Robert	Klupacs	ES Cell International - Monash Medical Centre	
	Prof	Alan	Trounson	Monahs Institute of Reproductive and Development	
	Ass Prof	Martin	Pera	Monash Institute of Reproduction and Development	
	Prof	Jock	Findlay	Infertility Treatment Authority	
	Dr	John	McBain	Melbourne IVF	

	Mr	Gordon	Baker	Melbourne IVF	
	Ms	Donna	Howlett	Monash IVF - 4th Floor, Epworth Hospital	
	Mr	Robert	McLachlan	Monash IVF - 4th Floor, Epworth Hospital	
	Ms	Adrianna	Pope	Monash IVF - Clayton Program	
	Mr	Colin	Armit	CSL Limited - Pharmaceutical Group	
	Prof	Richard	Wettenhall	Department of Biochemistry	
	Prof	Bob	Williamson	Murdoch Children's Research Institute	
	Ass Prof	Julian	Savulescu	Murdoch Children's Research Institute	
	Dr	Margaret	Brumby	Walter & Eliza Hall Institute	
	Dr	Trevor	Kilpatrick	Walter & Eliza Hall Institute	
	The Rev'd	Alan	Nicholls	Anglican Diocese of Melbourne	
	The Rev'd	Alan	Nichols	Anglican Diocese of Melbourne	
	Mr	Bill	Muehlenberg	Australian Family Association	
	Rev	Norman	Ford	Caroline Chisolm Centre for Health Ethics	
	Most Rev'd	Dennis	Hart	Catholic Archdiocese of Melbourne	Father Anthony Fisher
	Fr	Anthony	Fisher	Catholic Archdiocese of Melbourne	
		The President		Executive Council of Australian Jewry	
	Assoc Prof	Helge	Kuhse	Monash Centre for Human Bioethics School of Philosophy and Bioethics	
	Dr	Lynn	Gillam	Murdoch Children's Research Institute	
	Mr	Peter	Beriman	Pro-Life Victoria	
	Ms	Margaret	Tighe	Right to Life	Dr Mathew Piercey
	Dr	Matthew	Piercey	Right to Life	
	Prof	Nicholas	Saunders	Faculty of Medicine	
	Ms	Helen	Szoke	Infertility Treatment Authority	
WA	Ass Prof	Alan	Harvey	Department of Anatomy & Human Biology University of Western Australia	
	Rev	Joseph	Parkinson	L J Goody Bioethics Centre	
	Dr	Kaye	Miller	WA Reproductive Technology Council	
	Mr	Philip	Matthews	WA Reproductive Technology Council	
	Dr	Mark	McKenna	WA Reproductive Technology Council	
	Dr	Beverly	Petterson	WA Reproductive Technology Council	

	Prof	Con	Michael	WA Reproductive Technology Council	
	Ass Prof	Jim	Cummins	WA Reproductive Technology Council Division of Veterinary & Biomedical Sciences	
	Dr	Sue	Fletcher	Australian Neuromuscular Research Institute Queen Elizabeth II Medical Centre	
	Dr	Fiona	Wood	Clinical Cell Culture Pty Ltd	
	Prof	John	Howell	Faculty of Medicine & Dentistry Australian Neuromuscular Research University of Western Australia	
	Dr	Peter	O'Leary	WA Department of Health Genomics Health	
	Dr	Jack	Goldblatt	WA Department of Health - Genomics Health	
	Dr	Hugh	Dawkins	WA Department of Health - Genomics Health	
	Prof	Peter	Klinken	WA Institute for Medical Research University of Western Australia	
	The Most Rev'd Dr	Peter	Carnley	Anglican Diocese of Perth	
	Prof	Darcy	Holman	Dept of Public Health - Uni of Western Australia	
	Ms	Stephanie	Knox	Genesis WA	
	Ms	Michelle	Kosky	Health Consumers Council	
	Dr	Peter	Williamson	Murdoch University	
		The Manager		Pregnancy Lifeline	
	Ass Prof	Carol	Bower	TVW Telethon Institute of Maternal & Child Health	
	Prof	Fiona	Stanley	TVW Telethon Institute of Maternal & Child Health	
	Dr	Peter	Burton	Concept Fertility Centre - King Edward Memorial Hospital	
	Dr	Phil	Matson	Hollywood Fertility Centre - Hollywood Private Hospital	

	Dr	Anne	Jequier	Joondalup IVF - Joondalup Health Campus	
	Dr	Steve	Junk	Pivet Medical Centre	
	Dr	John	Yovich	Pivet Medical Centre	
	Dr	Maurice	Spillane	Princess Margaret and King Edward Memorial Hospitals HREC	
	Ass Prof	Martha	Hickey	Public Fertility Clinic - King Edward Memorial Hospital	

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-023

OUTCOME 9: HEALTH INVESTMENT

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS

Written Question on Notice

Senator Gibbs asked:

(a) Could you explain the detail of how this system will work?
(b) What is the time frame for each of the three components of the measure?
(c) What definition of 'outer metropolitan' is the department using?
(d) Are areas like Ipswich, Redcliffe and Caboolture included in the definition? (If not, why not?)
(e) How will the department decide the number of doctors going to each of the outer metropolitan areas?
(f) Will it be broken down based on population or on actual GP numbers in the area?
(g) How long does the department expect it to take before the measures start having an effect?
(h) How much higher will the Medicare rebate be for doctors who agree to work in a designated outer metropolitan area?
(i) What sort of 'specialist trainees' who are currently denied access to Medicare will be able to access it under this measure? How will department determine which trainees qualify. Will it be based on need in a particular region?
(j) Is there any capacity for the department to offer positive incentives to encourage female doctors to areas where the number of female doctors is particularly low (such as Ipswich)?

Answer:

(a) The More Doctors for Outer Metropolitan Areas Measure will consist of three components:

- allowing specialist trainees and researchers to work in supervised general practice programs in designated outer metropolitan areas and encouraging these doctors to work after-hours and on weekends;
- requiring doctors undertaking the general stream of the general practice training program to train in designated outer metropolitan areas; and
- allowing doctors who have not achieved vocational recognition and who undertake a 'fast track' vocational registration program and who agree to work in designated outer suburban areas, to become eligible to attract the higher level of Medicare rebate.

Details of how the individual programs will work are currently being developed.

(b) The three components of this measure are to commence in 2003.

(c) For the purposes of this Measure a definition of outer metropolitan has been developed. In the context of the Measure, 'outer metropolitan' means "the part of the capital city Statistical Division (using the 2001 Australian Standard Geographic Classification definition) that lies outside the 1991 Urban Centre (UCL) area of the capital city".

(d) The Statistical Local Area (SLA) in which Caboolture is located (Caboolture (S) Central) is located in the outer metropolitan zone of Brisbane and is eligible for inclusion on the Measure in 2003. Parts of the SLA in which Ipswich is located (Ipswich (C) Central) are located in the outer metropolitan zone of Brisbane but are not eligible for inclusion on the Measure in 2003 as this SLA does not currently exhibit a workforce shortage. However, parts of Ipswich (C) East are located in the outer metropolitan zone of Brisbane and are eligible for inclusion on the Measure in 2003. The SLA in which Redcliffe is located (Redcliffe Scarborough) is not eligible for the Measure as it is not located in the outer metropolitan zone of Brisbane.

(e) The allocation of doctors will be consistent with the level of workforce shortage in each SLA. Levels of workforce shortage will be monitored by the Department each year to ensure that there is an appropriate distribution of medical services in the outer metropolitan area.

(f) The statistics used by the Department in determining outer metropolitan 'districts of workforce shortage' are based on the number of full time equivalent medical practitioners per 100 000 population. This is then compared to a national benchmark so as to ascertain which areas are relatively undersupplied.

(g) Once an eligible medical practitioner takes up a placement on one of the programs, the benefits to the community will start immediately, with the introduction of more general practitioners providing medical services to the area. The Department will review the progress of the measure each year and generate reports on the success of the measure.

(h) Medical practitioners participating on the Specialist Trainees and Medical Researchers Program will have access to A2 rates when providing medical services as part of the Program. Medical practitioners participating on the Other Medical Practitioners and GP Registrars programs will have access to the higher A1 rates when providing medical services as part of the program.

(i) For the purposes of the Specialist Trainees and Medical Researchers Program, a specialist trainee is a medical practitioner who:

i. has obtained an Australian medical degree or is an overseas-trained medical practitioner who has passed the Australian Medical Council (AMC) examinations and met the AMC's English language proficiency requirements;
ii. has completed internship or, in the case of overseas trained doctors, supervised training in relation to a primary medical degree for AMC purposes;
iii. is registered to practice with a State Medical Registration Board; and
iv. is currently enrolled in and undertaking a training course of one of the approved Specialist Colleges (excluding the Royal Australian College of General Practitioners) that are listed in Part 1 of Schedule 5 of the Health Insurance Regulations.

Specialist trainees who meet these criteria and who have been nominated by a participating practice in an outer metropolitan district of workforce shortage will be considered for inclusion on the Program.

(j) The Department does not currently have an initiative or program aimed at increasing the number of female medical practitioners to areas that have a high number of male doctors. However, the Department does encourage female doctors to work in these areas where possible.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-032

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC GRANTS INVOLVING HUMAN EMBRYONIC STEM CELLS

Hansard Page: CA 261

Senator Harradine asked:

Could you provide us with the full details of NHMRC grants to projects involving research in human embryonic stem cells, which have recently received human ethics approval from the institution, and are due to commence funding in June this year.

Answer:

The NHMRC has awarded two research grants which involve the use of human embryonic stem cells. Both projects have recently received institutional human ethics committee approval, and are expected to commence in June 2002.

- a Partnership Grant *Diabetes Collaborative Research Creating beta-Cells to Cure Type 1 Diabetes* jointly supported by the NHMRC and the Juvenile Diabetes Research Foundation (Chief Investigator: Dr Andrew Elefanty, Monash University, a total funding of $4.26 million over 5 years); and

- a Project Grant *Control of Growth and Differentiation of Normal and Malignant Human Pluripotent Stem Cells* (Chief Investigator: A/P Martin Pera, Monash University, a total funding of $482,640 over 3 years).

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2002-2003, 5 & 6 June 2002

Question: E02-034

OUTCOME 9: HEALTH INVESTMENT

Topic: NATIONAL INSTITUTES OF HEALTH FUNDING

Hansard Page: CA 264

Senator McLucas asked:

Do we know how many projects or institutions might be affected, with current pieces of work being done now that may have NIH funding as well as Australian funding. Could we get a list of those?

Answer:

Though it is understood that the NIH proposed policy change will not be retrospective, the most recent data (US financial year: 1 October 2001 to 30 September 2002) provides an indication of the possible future impact.

In the 2001-02 US financial year, the NIH awarded 44 grants to Australian researchers with a total funding of $US7,496,354 (Attachment A).

All 44 NIH grantees are based at public research institutions in Australia.

18 of the 44 grantees received NHMRC funding (Attachment B). The NHMRC funding provided to these 18 researchers was $A17,964,601 in the 2001 calendar year (37 Projects Grants and four Fellowships), and $A13,319,604 in the 2002 calendar year (20 Projects Grants, two Program Grants and five Fellowships).

Whilst the NHMRC Fellowships were specifically for salary support, a large proportion of the projects supported by the NHMRC appear to be closely related to the work supported by the NIH.

AWARDS IN FOREIGN COUNTRIES, effective 02/19/2002		
Source: IMPAC II - CURRENT, by_state.foreign.FY2001.sql		
NIH Grants and Awards for Fiscal Year 2001		
PI Name	**Grant Number**	**Amount Awarded (US $)**
Brookes, Simon J	ADELAIDE, Flinders University of South Australia	$198,513
	5R01DK056986-02	
	Neural Mechanisms of Motility and Motility-Related Pain	
D'Andrea, Richard J	ADELAIDE, Institute of Medical and Vet Science	
	2R01HL060657-04	$200,000
	Activated Mutants as Probes of GM-CSF Receptor Function	
Cheng, Qin	BRISBANE, Queensland Institute of Medical Research	
	5R01AI047500-03	$137,328
	Evolution of Drug Resistance in Plasmodium Falciparum	
Hayward, Nicholas K	BRISBANE, Queensland Institute of Medical Research	$311,824
	1R01CA088363-01A1	
	Pathways from Genotype and Environment to Melanoma	
Lavin, Martin F	BRISBANE, Queensland Institute of Medical Research	$143,740
	5R01CA086873-02	
	Role of ATM In DNA Damage Recognition	
Martin, Nicholas G	BRISBANE, Queensland Institute of Medical Research	$433,058
	1R01AA013326-01	
	Molecular Epidemiology of Alcoholism 1--Candidate Gene	
Moss, Denis J	BRISBANE, Queensland Institute of Medical Research	$200,000
	1R21CA090139-01	
	Treatment of EBV Associated Lymphoproliferative Disease	
Powell, Lawrie W	BRISBANE, Queensland Institute of Medical Research	$150,000
	5R01DK057648-02	
	Hemochromatosis--Mechanisms and Novel Therapies	
Stenvers, Kaye L	MELBOURNE, Ludwig Institute for Cancer Research	$45,560
	1F32CA090034-01/1F32CA090034-01X1	
	TGFBRIII in Normal and Malignant Liver Growth	
Anderson, Robin L	MELBOURNE, Peter MacCallum Cancer Institute	$135,000
	1R01CA090291-01	
	Genes Important in Breast Cancer Metastasis	
Anderson, Robin L	MELBOURNE, Peter MacCallum Cancer Institute	$88,217
	R01CA081421-03	
	Apoptosis--Role of HSP72 and Novel Death Antagonists	

Simmons, Paul J	MELBOURNE, Peter MacCallum Cancer Institute	$175,000
	1R01HL069145-01	
	Hematopoietic Potential of the Epidermis	
Jane, Stephen M	MELBOURNE, Royal Melbourne Hospital	$175,000
	1R01HL069232-01	
	Role of LBP-1a and p14 NF-E4 in Gamma Globin Gene Expre*	
Hopper, John L	PARKVILLE, University of Melbourne	$672,476
	2U01CA069638-07	
	Australian Breast Cancer Family Registry	
Thompson, Erik W	PARKVILLE, University of Melbourne	$75,000
	5R21CA087244-02	
	Epithelio Mesenchymal Transition in Breast Cancer	
Jass, Jeremy R	QUEENSLAND, University of Queensland	$174,951
	3U01CA074778-04S1	
	Australasian Colorectal Cancer Family Study	
Khromykh, Alexander	QUEENSLAND, University of Queensland	$150,000
	5R21AI048420-02	
	Kunjin Virus Replicon as a Vector for HIV Vaccine.	
Mowry, Bryan J	QUEENSLAND, University of Queensland	$117,713
	5R01MH059588-03	
	Molecular Genetics of Schizophrenia	
Baker, David L	SUBIACO, Princess Margaret Hospital for Children	$70,423
	5U10CA079726-03	
	Children’s Cancer Group--Competitive Grant Renewal	
Watt, Paul M	SUBIACO, TVW Telethon Institute-Child Health Res	$100,000
	1R21CA091150-01	
	Inhibition of Telomerase Actiivity in Breast Cancer	
Watt, Paul M	SUBIACO, TVW Telethon Institute-Child Health Res	$100,000
	1R21CA091267-01	
	Mechanisms of Genomic Instability in Cancer	
Watt, Paul M	SUBIACO, TVW Telethon Institute-Child Health Res	$100,000
	5R21CA084096-02	
	Specific Peptide Inhibition of Oncoprotein Interactions	
Jacques, Nicholas A	SYDNEY, Institute of Dental Research	$254,730
	5R01DE013234-03	
	Bacterial Gene Expression in Model Oral Biofilms	
Carr, Andrew D	SYDNEY, Natl Centre/HIV Epidemiology/Clinical Res	$200,000
	5R01HL065953-02	

	Protease Inhibitor Related Atherosclerosis in HIV	
Chapman, Simon	SYDNEY, University of Sydney	$199,602
	1R01CA087110-01A1	
	Analysis of Tobacco Industry Documents--Asia/Australia	
Christie, Macdonald J	SYDNEY, University of Sydney	$91,579
	5R01DA012926-02	
	Opioid Withdrawal Mechanisms in Midbrain Neurons	
Farrell, Geoffrey C	SYDNEY, University of Sydney	$132,100
	5R01DK056402-03	
	Chronic Hepatitis C: Molecular & Cellular Markers	
Harper, Clive G	SYDNEY, University of Sydney	$204,714
	5R24AA012725-02	
	Brain Tissue Resource Center for Alcohol Research	
Harvey, Richard P	SYDNEY, Victor Chang Cardiac Research Institute	$135,651
	1R01HL068885-01	
	Genetic Modifiers of Congenital Heart Disease	
Trounson, Alan O	VICTORIA, Monash University	$451,019
	5U01HD038228-03	
	Cryopreservation of Ejaculated and Epididymal Sperm	
Simpson, Evan R	VICTORIA, Prince Henry's Institute of Medical Res	$160,350
	5R37AG008174-13	
	Aromatase in Adipose--Relationship to Aging and Cancer	
Adams, Jerry M	VICTORIA, Walter and Eliza Hall Inst Medical Res	$144,645
	5R01CA080188-03	
	Mechanisms in The Regulation of Apoptosis	
Alexander, Warren S	VICTORIA, Walter and Eliza Hall Inst Medical Res	$161,487
	5R01HL062275-03	
	Regulation of Hematopoiesis by Thrombopoietin	
Brodnicki, Thomas C	VICTORIA, Walter and Eliza Hall Inst Medical Res	$43,772
	5F32DK009900-03/5F32DK009900-03X1	
	Diabetes Susceptibility Genes	
Cory, Suzanne	VICTORIA, Walter and Eliza Hall Inst Medical Res	$157,500
	5R01CA043540-14	
	Oncogene Induced Leukemogenesis in Transgenic Mice	
Cowman, Alan F	VICTORIA, Walter and Eliza Hall Inst Medical Res	$123,462
	5R01AI044008-03	
	Adherence of Malaria Infected Red Cells	

Foote, Simon J	VICTORIA, Walter and Eliza Hall Inst Medical Res	$200,000
	1R01AI046485-01A1	
	Identifying Host Response Genes to Malaria	
Foote, Simon J	VICTORIA, Walter and Eliza Hall Inst Medical Res	$250,000
	5R01AI047192-02	
	Finding Genes for Host Response to Leishmania Major	
Metcalf, Donald	VICTORIA, Walter and Eliza Hall Inst Medical Res	$180,000
	5R01CA022556-23	
	Differentiation of Granulocytes and Macrophages	
Schofield, Louis	VICTORIA, Walter and Eliza Hall Inst Medical Res	$126,940
	5R01AI045548-03	
	Immunobiology of Malaria Glycosylphosphatidylinositol	
Schofield, Louis	VICTORIA, Walter and Eliza Hall Inst Medical Res	$250,000
	5R01AI047104-02	
	A Chemically Synthetic Anti-Toxic Vaccine Against Malaria	
Truscott, Roger J	WOLLONGONG, University of Wollongong	$75,000
	1R01EY013570-01	
	Nuclear Cataract: Role of UV Filters and Lens Barrier	
Total Grants: 44	**Total Funding: US $7,496,354**	

Grant Id	Grant Type	Scientific Title	Admin Institution	$
160057	NHMRC Project Grant	Mechanosensitive afferent nerves and gastrointestinal motility	Flinders University of South Australia	
160078	FELLOWSHIP	Mechanosensitive afferent nerves & gastrointestinal motility	Flinders University of South Australia	
222097	PROGRAM	Queensland Institute of Medical Research	Queensland Institute of Medical Research	4,(
				**4,(
164815	NHMRC Project Grant	TGF-beta receptor type III in normal and malignant liver growth: Modulation of TGF-beta activity	Ludwig Institute for Cancer Research	
145786	NHMRC Project Grant	CD164: A sialomucin adhesion molecule with potent growth inhibitory properties	University of Melbourne	
107501	NHMRC Project Grant	Studies of nf-e4, a novel fetal/erythroid specific factor involved in fetal globin gene regulation	Royal Melbourne Hospital Research Foundation	
146513	FELLOWSHIP	Ongoing Uncoupled Research Fellowship	Royal Melbourne Hospital Research Foundation	
170215	FELLOWSHIP	Ongoing uncoupled research fellowship	University of Melbourne	
980993	NHMRC Project Grant	Australian NHMRC Twin Registry	University of Melbourne	
991129	NHMRC Project Grant	Genetic and statistical analyses of case-control-family studies of breast and colorectal cancer	University of Melbourne	
142911	NHMRC Project Grant	Kunjin virus replicon-based vaccine vectors: new developments and applications	University of Queensland	
142983	NHMRC Project Grant	Molecular analyses of flavivirus RNA replication, encapsidation, and complementation	University of Queensland	
143027	NHMRC Project Grant	A genetic study of schizophrenia in the Brahmin of Tamil Nadu	University of Queensland	
211955	NHMRC Project Grant	Random aptamers to probe SCL function in vivo.	University of Western Australia	
153857	NHMRC Project Grant	Analysis of tobacco industry internal documents: Australia	University of Sydney	
107489	NHMRC Project Grant	Synergism between opioids and other agents at central primary afferent synapses	University of Sydney	
211168	NHMRC Project Grant	Differentiation of multiple phenotypes of rostral ventromedial medulla neurons and their role in pain	University of Sydney	

211169	NHMRC Project Grant	Mechanisms of opioid receptor desensitisation in single neurons	University of Sydney	
997042	FELLOWSHIP	functional neuroimaiging of pain processing in humans	National Ageing Research Institute	
109002	NHMRC Project Grant	Role of Homeobox Gene Nkx2-5 in Heart Development and Congenital Heart Disease	Victor Chang Cardiac Research Institute	
213402	NHMRC Project Grant	Genetic and Molecular Dissection of Laterality in the Developing Heart	Victor Chang Cardiac Research Institute	
169010	NHMRC Project Grant	Lipid metabolism in the Aromatase Knock-out Mouse (ArKO)	Prince Henry's Institute of Medical Research	
219248	NHMRC Project Grant	Equipment Grant	Prince Henry's Institute of Medical Research	
215499	NHMRC Project Grant	Transitional Institutue Grant	Walter and Eliza Hall Institute	1,
222099	PROGRAM	Walter & Eliza Hall Institute	Walter and Eliza Hall Institute	5,
				6,
162707	NHMRC Project Grant	Understanding The Role of Human Lens UV Filters in Age-Related Cataract	University of Wollongong	
213121	FELLOWSHIP	Uncoupled Research Fellowship	University of Wollongong	

Total 13,