Community Affairs
Legislation Committee

Examination of Budget Estimates 2003-2004

Additional Information Received

VOLUME 5

Outcomes: 4, 5, 6, 7, 8, 9

HEALTH AND AGEING PORTFOLIO

NOVEMBER 2003

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 2003-2004

Included in this volume are answers to written and oral questions taken on notice relating to the budget estimates hearings on 2, 3 and 5 June 2003

HEALTH AND AGEING PORTFOLIO

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Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-066

OUTCOME 4: QUALITY HEALTH CARE

Topic: PBS BLOOD PRODUCTS

Written Question on Notice

Senator Harradine asked**:**

Why are blood products, used for the treatment of diseases and conditions, not on the Pharmaceutical Benefits Scheme?

Answer:

Blood products are not on the Pharmaceutical Benefits Scheme (PBS) because they are made available to the Australian community free of charge.

Historically, plasma-derived products, including factors VIII and IX, have been manufactured from plasma donated to the Australian Red Cross Blood Service (ARCBS) and made available to Australians free of charge. The cost of collecting the plasma and the manufacturing of that plasma into finished products has been funded by governments. State and Territory legislation prohibits the sale of blood and blood products. It would also be difficult in terms of equity to fund recombinant products under the PBS and require patient moieties when the plasma derived products are provided free of charge to patients.

The department notes that blood and blood products are used widely in Australia's public hospitals where under the Medicare principles, services are provided to public patients free of charge.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-067

OUTCOME 4: QUALITY HEALTH CARE

Topic: HAEMOPHILIA TREATMENT – FUNDING STRUCTURE

Written Question on Notice

Senator Harradine asked:

Is it the Department's view that CSL could have liability under the defective product regime of the Trade Practices Act? Has the Department sought or will it seek legal advice on this? If so, please provide a copy.

Answer:

The Department can find no record of ever obtaining advice on the application of the defective product regime to CSL or CSL products. The Department accordingly can express no view on the matter. The application of the Trade Practices Act generally is a matter for the Department with policy responsibility for that Act.

The Department has no plans to seek such legal advice.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-068

OUTCOME 4: QUALITY HEALTH CARE

Topic: HAEMOPHILIA TREATMENT – FUNDING STRUCTURE

Written Question on Notice

Senator Harradine asked:

(a) Is the Department considering a new centralised funding structure with funds allocated specifically for recombinant therapy for haemophilia treatment? If so, please provide details of this funding structure. If not, why not?

(b) Please provide names of the relevant committees and their membership which make policy recommendations/decisions on these matters.

Answer:

(a) Yes. The Department, along with State and Territory health authorities, has developed a centralised funding structure for blood and blood products. Imported plasma-derived products and imported recombinant factors VIIa, VIII and IX, are included in these arrangements which will be managed by the National Blood Authority when it commences operations on 1 July 2003. The national cost of all blood and blood products will be jointly shared under an agreed cost share ratio of 63:37 between the Commonwealth and States and Territories.

Under these arrangements, the Commonwealth and States and Territories, through the Australian Health Ministers' Conference (AHMC), will determine the mix and volumes of the blood products they need based on the clinical demand for each product in accordance with clinical practice and clinical usage guidelines. Health Ministers will therefore have the opportunity to review the usage of products and funding in light of the clinical guidelines being developed by either the National Health and Medical Research Council or the Australian Haemophilia Centre Directors' Organisation.

(b) The relevant committee which makes policy and funding recommendations to AHMC on these matters is the Jurisdictional Blood Committee. See Attachment A.

Attachment A

MEMBERSHIP OF THE JURISDICTIONAL BLOOD COMMITTEE

The following jurisdictional members comprise the Jurisdictional Blood Committee:

NSW	Mr Bill Heiler	Manager, Clinical Services NSW Department of Health
VIC	Dr Chris Brook	Director Rural and Regional Health and Aged Care Services Victorian Department of Human Services
QLD	Ms Madonna Cuthbert	A/g Manager Health Funding and Systems Development Unit Queensland Health
WA	Dr Dorothy Jones	Principal Medical Officer Health Department of Western Australia
SA	Prof Brendon Kearney	Executive Director Clinical Services Department of Human Services
TAS	Dr Jack Sparrow	Medical Consultant Department of Health and Human Services
ACT	Dr Paul Dugdale	Chief Health Officer ACT Health
NT	Ms Sandy Spears	Services Development Officer Department of Health and Community Services
CW	Dr Louise Morauta (Chair)	First Assistant Secretary Acute Care Division Department of Health and Ageing

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-069

OUTCOME 4: QUALITY HEALTH CARE

Topic: THE STEPHEN REVIEW

Senator Harradine asked:

In 2001, the Stephen Review found that the scheme for imported blood products and related products, including Factor VIIa, was agreed to by the Commonwealth, States and Territories in 1997.

(a) Please explain why the agreements required to underpin the scheme have not been finalised after six years.

(b) Does the Department acknowledge that this impasse has meant that those suffering haemophilia with an inhibitor are continuing to suffer needlessly with pain and increased joint damage?

(c) What is the Department doing to try to progress the scheme?

(d) Will the National Blood Authority list Factor VIIa in the National Blood Agreement in sufficient quantity to be the first-line treatment for the control of all spontaneous and trauma related bleeds for all haemophilia adults and children with inhibitors?

Answer:

(a) In 1997 the Australian Health Ministers' Advisory Council (AHMAC) agreed, amongst other things, that the cost of importing blood and blood related products including recombinant factor VIIa be cost shared on a 50:50 basis between the Commonwealth and the relevant State and Territory health authority. While a Memorandum of Understanding (MoU) for the funding of imported blood and blood related products was offered to each State and Territory jurisdiction, not all jurisdictions took up the offer as they were awaiting the outcome of the *Review of the Australian Blood Banking and Plasma Product Sector* (Stephen Review). However, irrespective of whether an MoU was in place, the Commonwealth has provided its 50% share of the costs in accordance with the AHMAC decision up to 30 June 2003. On 1 July 2003 the new National Blood Agreement signed by the Commonwealth and all States and Territories governs all inter-jurisdictional arrangements.

(b) The Department does not consider that the financing arrangements between jurisdictions have affected access to factor VIIa.

(c) The National Blood Agreement has overtaken earlier inter-jurisdictional financial arrangements from 1 July 2003.

(d) Since 1997 rFVIIa has been provided for haemophilia patients with inhibitors, in line with the policy of Governments. This policy restricts the use of rFVIIa to life and limb threatening situations whilst acknowledging emerging clinical practice in the use of this product for the treatment of haemophilia patients with inhibitors in less severe situations. This will continue to be the policy of governments following the commencement of the NBA from 1 July 2003.

However, the Australian Haemophilia Centre Directors' Organisation has been asked to develop national clinical guidelines for treating haemophilia patients with inhibitors as a matter of high priority. Once guidelines have been developed, Governments will be in a position to consider the policy for the provision of rFVIIa, and to amend that policy if necessary.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-070

OUTCOMES 4: QUALITY HEALTH CARE

Topic: CSL - INVOICING AND FINANCIAL MANAGEMENT

Written Question

Senator Harradine asked:

The Department informed the Committee that their main concern with regard to CSL was to do with invoicing and financial management.

(a) Did Departmental officers raid the CSL site in late 1998 following the discovery that CSL had broken safety regulations governing the importation of blood? I would appreciate further details

(b) Is it true that the Auditor-General found that, from December 1998 to June 1999, CSL processed blood from overseas without the approval of the Department? I would appreciate details as to what the Department did to address this situation.

(c) Is it true that in 1994 when CSL was privatised, the Government gave an indemnity to the new owners against any claims that might be made against CSL because of contaminated blood? Please provide a copy of documents involved in this case including the details of the indemnity.

Answer:

(a) An unannounced audit of CSL Bioplasma, Broadmeadows, Victoria was conducted by four officers of the TGA on 24 November 1998 to investigate possible importation by CSL of plasma from USA without the approval of the TGA. This audit was initiated when it was noted by a TGA officer, who was in the USA on another task, that CSL may have imported USA plasma contrary to a 1996 agreement with the TGA to submit Plasma Master Files for all imported plasma.

The unannounced audit confirmed that CSL had imported plasma from the USA without informing the TGA. The TGA took immediate action (on 7 December 1998) to amend the Therapeutic Goods Act 1989 to require any Australian manufacturer of blood products to submit plasma master files for these products where the plasma was obtained from outside Australia. The new legislation also required that plasma from any foreign source must not contaminate any Australian product with any blood borne pathogens.

In May 1999, the Minister for Health and Aged Care commissioned an independent inquiry into the incident of the processing of foreign plasma by CSL without regulatory requirements having been met. The independent expert's report advised that CSL acknowledged it had failed to meet regulatory requirements of the TGA for foreign plasma but that there was no risk to viral safety arising as a result of processing the foreign plasma.

(b) The Auditor-General reported (Audit Report No. 24 of 1999-2000) that "between 7 December 1998, and 10 June 1999, with TGA's concurrence, CSL continued to process plasma from four foreign countries without having been advised in accordance of the revised requirements of the Manufacturing Principles".

This related to plasma that the TGA had agreed, prior the introduction of the new Manufacturing Principles on 7 December 1998, could be imported. The evaluation of the plasma master files relating to this plasma was well advanced at the time the new Manufacturing Principles were introduced, with only minor technical issues outstanding. The TGA was satisfied that there was no risk of transferring blood borne pathogens to other blood products manufactured by CSL at that time.

(c) At the time CSL Limited was privatised in 1994, the Commonwealth indemnified CSL for certain existing and potential claims made for personal injury, loss or damage suffered through therapeutic use of certain products manufactured by CSL prior to its privatisation date. The indemnity covered claims where claimants acquired HIV, Hepatitis, Pertussis, Polio, Asbestosis and Creutzfeldt-Jakob Disease (CJD) from human growth hormone and human pituitary gonadotrophin.

In addition, under the Plasma Fractionation Agreement and the Diagnostic Products Agreement, the Commonwealth provided a more limited indemnity against claims by any persons who become HIV-positive or contracted an AIDS-related condition or Hepatitis as a result of the products manufactured by CSL under either of these Agreements. Any Commonwealth exposure is further limited by CSL having been able to obtain insurance cover against AIDS-related and Hepatitis claims since then.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 June 2003

Question: E03-048

OUTCOME 4: QUALITY HEALTH CARE

Topic: MENTAL HEALTH

Written Question on Notice

Senator Denman asked:

(a) One of the recommendations of the recent report 'Out of Hospital, Out of Mind' released by the Mental Health Council of Australia, in April 2003, is for the establishment of an independent commission to report on progress of mental health reform in Australia and investigate ongoing abuse or neglect – does the Department or Minister have a response on this recommendation?

(b) That report also suggests that currently, 62% of persons with mental disorders do not utilise mental health services and goes on to list a number of reasons. One of the reasons is the poor distribution and costs associated with the services. What steps does the Department undertake to ensure that mental health services are well distributed and affordable?

Answer:

(a) Yes. The Minister wrote to Dr Sev Ozdowski, Human Rights Commissioner on 19 June 2003 saying that whist she acknowledged the sentiments behind the call for the establishment of a National Mental Health Commission as currently exists in New Zealand, she felt that the federated system that exists in Australia renders such a Commission inappropriate.

(b) The 62% referred to in the 'Out of Hospital, Out of Mind' Report comes from the 1997 report by the Australian Bureau of Statistics (ABS) 'Mental Health and Wellbeing Profile of Adults'. The ABS report did not specifically identify the reasons why people did not use services, as suggested in the 'Out of Hospital, Out of Mind' Report. However, the ABS report does indicate that of those people who met criteria for a mental disorder but did not use services for mental health problems, the vast majority of individuals – around 75 per cent – expressed the view that they had no perceived need for help. This may indicate a perception on the part of these people that they do not, in fact, have a mental health or substance abuse problem.

Allocation of Commonwealth health funding to State and Territories occurs under the Australian Health Care Agreements. The allocation and distribution of such resources to public specialist mental health services is a matter for State and Territory Governments.

In relation to mental health services provided under the Medical Benefits Schedule, including services provided by general practitioners and private psychiatrists, all such services are subject to rebate.

Further, under the Better Outcomes in Mental Health Initiative the Department is providing resources to support general practitioners in the provision of quality mental health care. To date, some 2,700 general practitioners have enrolled in the scheme and the percentage uptake of general practitioners has been greater in rural and remote areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-130

OUTCOME 4: QUALITY HEALTH CARE

Topic: BLOOD PRODUCTS

Hansard Page: CA 47

Senator Harradine asked:

How many of those in the haemophiliac community have been affected by blood-borne diseases?

Answer:

The Department does not hold this information. The Department sought advice from the Australian Bleeding Disorder Registry (ABDR) and the New South Wales Department of Health, as New South Wales does not currently contribute to the ABDR.

The ABDR advises it has only been collecting data on people with haemophilia for four to five years and has not yet achieved 100% data capture.

People with haemophilia A and B may be classified into three groups: (a) severe haemophilia (1% or less clotting factor); (b) moderate haemophilia (2-5% clotting factors); and (c) mild haemophilia (greater than 5% clotting factors).

Some types of haemophilia are quite rare in Australia, with population sizes of less than 100. There is an ethical requirement to maintain the confidentiality of patient data. The risk of identifying a single individual from data increases substantially when data are tabulated for small subgroups of the population. Extreme caution is warranted when the population is less than 100. Therefore, for those types of haemophilia with a population of less than 100, HIV and hepatitis C status will be presented as a percentage of the population rather than as a number of individuals.

The ABDR advises that for all States except NSW:

(a) of the 333 individuals registered with severe haemophilia A, 206 (or 62%) have hepatitis C and/or HIV;
(b) of the 130 individuals registered with moderate haemophilia A, 83 (or 64%) have hepatitis C and/or HIV; and
(c) of the 394 individuals registered with mild haemophilia A, 157 (or 40%) have hepatitis C and/or HIV.

Thus 446 (or 52%) of a total of 857 people with haemophilia A have hepatitis C and/or HIV.

(d) there are less than 100 individuals registered with severe haemophilia B, of whom 58% have hepatitis C and/or HIV;
(e) there are less than 100 individuals registered with moderate haemophilia B, of whom 42% have hepatitis C and/or HIV; and
(f) there are less than 100 individuals registered with mild haemophilia B, of whom 40% have hepatitis C and/or HIV.

Thus 46% of people with haemophilia B have hepatitis C and/or HIV.

New South Wales Health advises that in New South Wales:

(a) of 748 patients who have attended haemophilia Centres in NSW, including those patients with haemophilia A, B, C or who are carriers of haemophilia, 225 (or 30%) have hepatitis C; and
(b) of 748 patients who have attended haemophilia Centres in NSW, including those patients with haemophilia A, B, C or who are carriers of haemophilia, 52 (or 7%) have HIV.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-131

OUTCOME 4: QUALITY HEALTH CARE

Topic: BLOOD PRODUCTS (HEP C AND HIV)

Hansard Page: CA 47

Senator Harradine asked:

Is the Department aware that, of the 2,000 Australians who suffer the lifelong inherited blood-clotting condition of haemophilia, 80% have been infected with hepatitis C and 260 people have been infected with HIV through contaminated blood and blood products harvested by the Red Cross transfusion service and processed by CSL?

Answer:

The answer to question 130 also refers.

The number of people with haemophilia A and haemophilia B who were infected with the hepatitis C virus and HIV before the introduction of screening tests in 1990 (for hepatitis C) and 1985 (for HIV) is not available as there was no accurate data collected at that time.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2,3 & 5 June 2003

Question: E03 - 267

OUTCOME 4: QUALITY HEALTH CARE

Topic: AFTER HOURS PRIMARY MEDICAL CARE PROGRAM

Hansard Page: CA 503

Senator McLucas asked:

Can I please have a list of the twenty-seven sites funded by this program?

Answer:

Attached is a list of the 27 sites funded by the After Hours Primary Medical Care Program (as at the time of the Budget Estimates hearing).

ATTACHMENT A

The After Hours Primary Medical Care Development Grants Program

No	After Hours Primary Medical Care Sites	Location
1.	After Hours Doctor Pty Ltd, Tasmania	Southern Tasmania, TAS
2.	Canning Division of General Practice Ltd	Perth, WA
3.	Catholic Health Care Services	Hawkesbury, NSW
4.	Central Australian Division of Primary Health Care	Alice Springs, NT
5.	Central Coast Division of General Practice NSW	Central Coast, NSW
6.	Central Highlands Division of General Practice Ltd	Central Highlands, VIC
7.	Central West Victorian Division of General Practice	Grampians, VIC
8.	Central Wheatbelt Division of General Practice Inc	Central Wheatbelt, WA
9.	General Practice Education Australia	Melbourne, VIC
10.	Hornsby, Ku-ring-ai, Ryde Division of General Practice	Hornsby, NSW
11.	Hunter Urban Division of General Practice	Hunter Urban Region, NSW
12.	Ipswich and West Moreton Division of General Practice	Ipswich, QLD
13.	Logan Area Division of General Practice Pty Ltd	Logan, QLD
14.	Macarthur Division of General Practice	Campbelltown, NSW
15.	Mackay Division of General Practice Ltd	Mackay, QLD
16.	North West Melbourne Division of General Practice Limited	Melbourne, VIC
17.	NSW Central West Division of General Practice Ltd	Bathurst Region, NSW
18.	Perth and Hills Division of General Practice	Perth, WA
19.	Riverina Division of General Practice Inc	Wagga Wagga, NSW
20.	Rural Doctors Workforce Agency Inc	Adelaide, SA
21.	Sunshine Coast Division of General Practice	Gympie, QLD
22.	Sunshine Coast Private Hospital	Sunshine Coast, QLD
23.	The Goulburn Valley Division of General Practice Ltd	Shepparton, VIC
24.	Maitland After Hours GP Service	Maitland, NSW
25.	The Woolgoolga and District Retirement Village	Woolgoolga, NSW
26.	Townsville Division of General Practice Ltd	Townsville, QLD
27.	Whitehorse Division of General Practice	Melbourne, VIC

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-047

OUTCOME 5: RURAL HEALTH CARE

Topic: SHORTAGE OF SPECIALISTS

Written Question on Notice

Senator Denman asked:

(a) What figures does the Department have on the current shortages of Allied Healthcare professionals in rural and regional locations?

(b) Could you please list all of the initiatives currently being undertaken to address the shortages of all specialist surgeons in rural and regional locations?

Answer:

(a) The Department does not collect statistics on the Allied Health workforce in Australia. However, the Australian Institute of Health and Welfare has produced the following labour force series:

- Health and Community Labour Force, National Health Labour Force Series No. 19;
- Pharmacy Labour Force to 2001, National Health Labour Force Series No.25;
- Podiatry Labour Force 1999, National Health Labour Force Series No. 23;
- Occupational Therapy Labour Force 1998, National Labour Force Series No. 21;
- Physiotherapy Labour Force 1998, National Health Labour Force Series No. 22;
- Optometrist Labour Force 1999, National Health Labour Force Series No.18.

(b) The Commonwealth funds a range of initiatives to support the rural specialist workforce and improve access to specialist services for people in rural Australia.

The Medical Specialist Outreach Assistance Program (MSOAP) is one component of the Regional Health Strategy that was announced in the 2000-01 Budget. The objectives of the program are to:

- Increase specialist services in areas of identified need;
- Facilitate visiting specialist and local health workforce relationships and communication; and
- Increase and maintain the skills of regional, rural and remote general practitioners and specialists.

MSOAP aims to improve the access of people living in rural and regional Australia to specialist services, by addressing some of the financial disincentives to specialists to providing outreach or visiting services. It provides funding to specialists to cover costs such as travel, accommodation, and communication with local medical practitioners through training/upskilling.

A number of surgical services are supported through MSOAP including a piloting of paediatric outreach surgical services in the Mallee region of Victoria and General Surgery in North Eastern Tasmania. In addition the program also supports the placement of medical specialist registrar training posts in rural areas. Of these, surgery is supported in Bendigo, Victoria.

In the Northern Territory, the Specialist Outreach Services program (jointly funded by the Commonwealth and Northern Territory Governments) provides medical specialist services to Indigenous communities in the Top End of the Territory while MSOAP provides similar services in the Central Australian region.

Under the Rural Advanced Specialist Training Support Program, funding is provided to the Royal Australasian College of Surgeons for two projects to support the rural surgical workforce:

- The coordination and administration of a rural surgical training stream. This is part of the general surgical training program. The number of continuing trainees in the rural stream was 44 in 2002. A further 8 each year will be recruited in 2003 and 2004. Eleven trainees have now completed their fellowship of which 7 have taken up rural consultant positions and 3 are undertaking post fellowship training prior to taking up rural practice. Trainees intending rural careers are mentored and provided with additional rural training experience.
- A rural locum coordination service that assists rural surgeons to find suitable locum relief and assists in the filling of vacancies.

The Advanced Specialist Training Posts in Rural Areas program provides funding on a cost shared basis to the States and the Northern Territory for establishing and maintaining advanced specialist training posts in regional and rural hospitals. This program provides opportunities for rural career development, enhances service development in the region and provides support to rural resident specialists. Over 30 posts are funded annually. In 2003, 9 of the posts were in surgery and surgical subspecialties.

Funding was included in both the 2002-03 and 2003-04 Budgets for the Support Scheme for Rural Specialists (SSRS) with the twin objectives of:

- Supporting medical specialists who are already in rural areas to maintain their professional standards and to reduce their professional isolation; and
- Encouraging specialists to either stay in rural areas or relocate to those areas where there is a shortage of specialists.

The Royal Australasian College of Surgeons is one of the colleges which has received funding for professional development projects through the SSRS.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-159

OUTCOME 6: HEARING SERVICES

Topic: FUNDING UNDER COMMUNITY SERVICES OBLIGATIONS (CSO)

Hansard Page: CA 99

Senator Crossin asked:

Can you provide this committee with figures on the number of people who received services under CSO in the last two quarters?

Answer:

Australian Hearing provides hearing services under Community Services Obligations (CSOs) to children to the age of 21 years, eligible adults with complex hearing rehabilitation needs, eligible clients living in remote locations and eligible Aboriginal and Torres Strait Islander people.

- In the September - December 2002 quarter, nine thousand two hundred and sixty (9,260) clients received hearing services under CSOs.

- In the December 2002 - March 2003 quarter, seven thousand six hundred and eighty eight (7, 688) clients received hearing services under CSOs.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-160

OUTCOME 6: HEARING SERVICES

Topic: TRAVEL EXPENDITURE BY AUSTRALIAN HEARING

Hansard Page: CA 99

Senator Crossin asked:

What percentage of the funding to Australian Hearing is spent on travel and what percentage on service provision?

Answer:

Senator Crossin's question was raised in the context of Australian Hearing providing services under the Australian Hearing Specialist Program for Indigenous Australians (AHSPIA).

Under the AHSPIA, expenditure for July 2002 to March 2003 is $477,825. Travel costs for the corresponding period are $69,878.

Total expenditure on the AHSPIA in 2001 - 2002 was $649,032. The travel expenditure for the corresponding period under AHSPIA was $61,484, which represents 9.47 per cent of total AHSPIA funding.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-161

OUTCOME 6: HEARING SERVICES

Topic: PERCENTAGE OF INDIGENOUS CLIENTS RECEIVING HEARING SERVICES

Hansard Page : CA 101

Senator Crossin asked:

Last year there were only 100 indigenous clients out of 130,000 what is the current figure?

Answer:

The figures quoted by Senator Crossin relate to voucher clients only and do not include clients of Australian Hearing who receive services under Community Service Obligations (CSOs). It must also be noted that data collected for Aboriginal and Torres Strait Islander clients under the Voucher system may not necessarily reflect the exact number of clients, as the Aboriginal and Torres Strait Islander identifier is optional.

- In the period 1 July 2001 to 30 June 2002, of 143,663 vouchers issued, 97 adult clients identified as Aboriginal and Torres Strait Islander people.

- In the period 1 July 2002 to 31 March 2003, of 116,759 vouchers issued (year-to-date), 65 adult clients identified as Aboriginal and Torres Strait Islander people.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-162

OUTCOME 6: HEARING SERVICES

Topic: PERCENTAGE OF INDIGENOUS AUSTRALIANS WITH HEARING PROBLEMS

Hansard Page: CA 101

Senator Crossin asked:

Would you provide an update on the percentage of Indigenous Australians who have reported ear or hearing problems?

Answer:

Data provided last year was generated by the National Health Survey 2001 produced by the Australian Bureau of Statistics. These surveys are only conducted every six years, therefore no further update is available.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-163

OUTCOME 6: HEARING SERVICES

Topic: BREAKDOWN BY LOCATION OF HEARING SERVICES TO INDIGENOUS AUSTRALIAN CLIENTS

Hansard Page : CA 102

Senator Crossin asked:

How many indigenous clients are there in urban, rural and remote areas who access hearing services?

Answer:

In the period 1 July 2002 to 31 March 2003 there were 1,328 clients who identified as Aboriginal and Torres Strait Islander seen by Australian Hearing under Community Service Obligations. Of this figure 287 were urban, 312 were rural and 729 were from remote areas.

Sixty five (65) adult clients identified as Aboriginal and Torres Strait Islander and were provided services under the Voucher system for the same period. The department does not classify these clients as being from either urban, rural or remote areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-164

OUTCOME 6: HEARING SERVICES

Topic: AUDIOLOGISTS' VISIT TO INDIGENOUS CLIENTS IN URBAN, RURAL AND REMOTE AREAS

Hansard Page : CA 103

Senator Crossin asked:

Would you provide a list of sites visited by Australian Hearing Audiologists?

Answer:

Attached are the permanent and visiting sites for Australian Hearing; the remote locations under the AHSPIA program; and, other sites visited under the AHSPIA program.

Australian Hearing permanent and visiting sites as at 31 March 2003

Permanent

Australian Capital Territory	1
New South Wales	26
Northern Territory	2
Queensland	16
South Australia	4
Tasmania	5
Victoria	20
Western Australia	4

Visiting

Australian Capital Territory	-
New South Wales	41
Northern Territory	1
Queensland	29
South Australia	16
Tasmania	10
Victoria	46
Western Australia	22

Remote AHSPIA sites visited – 1 July 2002 – 31 March 2003

Site	Location
Yirara College	Alice Springs
Congress ACCHO	Alice Springs
Amoonguna	10 km N/E Alice Springs
Papunya	100 km West Alice Springs
Ntaria	110km West Alice Springs
Mutitjulu	450 km S/W Alice Springs
Docker River	704 km S/W Alice Springs
Ngaanyatjarra Lands WA -	
Tjukurla	800 km S/W Alice Springs
Jamieson	800 km S/W Alice Springs
Warakurna	800 km S/W Alice Springs
Blackstone	800 km S/W Alice Springs
Wanarn	800 km S/W Alice Springs
Wingellina	800 km S/W Alice Springs
Pitjitjantjara Lands - SA -	
Amata	500 km South Alice Springs
Ernabella	500 km South Alice Springs
Indulkana	500 km South Alice Springs
East Arnhem Land	
Elcho Island	Arafura Sea via Gove

Groote Eylandt	Gulf Carpentaria via Gove
East Kimberlies (WA) -	
Kununurra	900 km S/W Darwin
Wyndham	100 km West Kununurra
Halls Creek	380 km South Kununurra
Kalumbaru	
Bath/Melville Island	
Milikapiti	Timor Sea via Darwin
Nguiu	Timor Sea via Darwin
Pirlamgimpi	Timor Sea via Darwin
Katherine Remote	
Kalkaringi	500 km S/W Katherine
Lajamanu	600 km S/W Katherine
Jilkamingan	140 km S/W Katherine
Mataranka	100 km S/E Katherine
Oenpeli	330 km East Darwin
Beswick	75 km East Katherine
Berunga	60 km East Katherine
Daly River/Port Keats Aboriginal Lands Trust	
Pt Keats (Wadeye)	380 km S/W Darwin
Daly River	
Peppimenari Com.	90 km from Pt. Keats
West Kimberlies (WA)	
Derby	221 Km South Perth
Fitzroy Crossing	256 Km West Derby
Northern Outback	
Jigalong	116 South Newman
Pilbara Region	
Roeburn	39 Km from Karratha
Wirraka Maya	Port Hedland
Yandayarra	
Mid and Far North Region	
Coober Pedy AMS	500 km north Pt. Augusta
Oodnadatta AMS	750 km north Pt. Augusta
West Coast Region	
Ceduna AMS	Ceduna
Yalata Comm.	250 km West Ceduna
Riverland Region	
Winkie	250 km N/E Adelaide
Far West/Central Plains NSW	
Brewarrina AMS	Brewarrina
Brewarrina Hosp.	Brewarrina
Brewarrina Comm H	Brewarrina
Brewarrina PS	Brewarrina
Far West Plains NSW	
Bourke AMS	Bourke

Far North Queensl'd	
Chillagoe PS	150 Km West Mareeba
Cape York	
Cooktown	Cooktown
Hopevale	30 Km North Cooktown
Lockhart River	530 Km North Cairns
Coen	430 Km North Cairns
Aurukun	590 Km N/W Cairns
Weipa	630 Km N/W Cairns
Kowanyama	470 Km N/W Cairns
Torres Strait	
Thursday Is HC	Torres Strait
Palm Island	70 Km N/W Townsville
South East Queensland	
Charleville AMS	630 Km West Toowoomba

AHSPIA sites visited (in addition to remote sites)
1 July 2002 – 31 March 2003

Australian Capital Territory	-
New South Wales	Redfern AMS Wunambiri Pre-Sc Kirinari Tharawal AMS Daruk AMS Wentworthville Area Armidale AMS Bingara School Wellington Community Hall Biralee Pre-Sc Biripi AMS Pius X Abl Co-op Durri AMS Coffs Harbour AMS Narrandera
Northern Territory	Batchelor Kormmilda College
Queensland	Mareeba PS Murray Upper Woorabinda Com. Cherbourg Comm Goodir AMS Woolloongabba Kambu AMS Kalwun AMS
South Australia	Kaurna Plains Carlton PS
Tasmania	Launceston
Victoria	Victorian AMS Bunnarong

	Bairnsdale Co-op Lake Tyers AT Nowa Nowa PS Morwell Co-op Ramahyuck Morwell (KODE) Njemda Co-op Rumbalara Co-op Ballarat Co-op Goolum Goolum Mildura ACCHS Robinval ACCHS Swan Hill Co-op Bendigo Co-op Kirrae HS
Western Australia	Kwinana Derbal Yerigan Geraldton Mullewa Our Lady of Mount Carmel

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-165

OUTCOME 6: HEARING SERVICES

Topic: COMPARISON OF NUMBER OF INDIGENOUS CHILDREN/ADULTS WHO RECEIVED HEARING SERVICES

Hansard Page : CA 104

Senator Crossin asked:

Would you please provide an updated number of indigenous children and indigenous adults who receive hearing services under the Hearing Services Program?

Answer:

The number of Community Service Obligation clients who received an audiological service in the period 1 July 2002 to 31 March 2003 who had identified as Aboriginal or Torres Strait Islander was 1,328. One hundred and sixty eight (168) of the 1,328 clients were adult clients with the remaining 1,160 clients being children.

Sixty five (65) people identifying as Aboriginal or Torres Strait Islander received hearing services under the voucher program.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-166

OUTCOME 6: HEARING SERVICES

Topic: NEW BUILDING STANDARDS THAT CONSIDER ACOUSTICS IN CLASSROOMS – SOUND FIELD SYSTEMS

Hansard Page; CA 105

Senator Lees asked:

Are the new 'building standards that consider acoustics in classrooms' in all States and Territories?

Answer:

Australian Standard AS2107 (2000) "Recommended design sound levels and reverberation times for building interiors" specifies that primary school classrooms should have unoccupied noise levels less than 45 dB(A), and preferably less than 35 dB(A), with reverberation times of 0.4 to 0.5 seconds.

These standards are not mandatory under federal law. It is a matter for each State and Territory to determine their own building standards/codes. On the information available to us we are unable to say which, if any, States and/or Territories have implemented these building standards.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-167

OUTCOME 6: HEARING SERVICES

Topic: TOTAL NUMBER OF CLIENTS AND PROPORTION OF INDIGENOUS CLIENTS

Hansard Page: CA 104

Senator Crossin asked:

Would you please provide the total number of clients and the proportion of them who are Aboriginal and Torres Strait Islander?

Answer:

The total number of clients who received services under the Community Service Obligations from July 2002 to March 2003 was 32,099. Of these clients 1,328 or 4.14% identified as Aboriginal and Torres Strait Islander clients.

The total number of vouchers issued from July 2002 to March 2003 was 116,759. Sixty five (65) or 0.056% of these vouchers were issued to people who identified as Aboriginal and Torres Strait Islander.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 June 2003

Question: E03-168

OUTCOME 6: HEARING SERVICES

Topic: AUSTRALIAN HEARING QUARTERLY REPORTS

Hansard Page : CA 106

Senator Crossin asked:

Would you please provide a copy of the last Australian Hearing quarterly reports?

Answer:
Information in the table below was provided by Australian Hearing to the Office of Hearing Services.

Australian Hearing – Community Service Obligations

	4th Qtr 2002	1st Qtr 2003	2nd Qtr 2003	3rd Qtr 2003
Total CSO Clients				
Children < 21 years	6,366	10,751	6,786	5,512
Adult Clients	2,042	4,400	2,474	2,176
Total CSO clients	**8,408**	**15,151**	**9,260**	**7,688**
Included in the total CSO clients are services provided to clients identifying themselves as Aboriginal and Torres Strait Islander				
Children < 21 years	255	278	324	282
Adult Clients	23	51	45	28
Adjustment to AHSPIA nos not previously reported, hence not distributed across all quarters				320
Total	**278**	**329**	**369**	**630**
AHSPIA clients				
Children < 21 years	267	199	246	330
Adult Clients	24	26	47	21
Total AHSPIA	**291**	**225**	**293**	**351**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 June 2003

Question: E03-169

OUTCOME 6: HEARING SERVICES

Topic: NUMBER OF AUSTRALIAN HEARING SPECIALST PROGRAM FOR INDIGENOUS AUSTRALIAN (AHSPIA) COMMUNIITES.

Hansard Page: CA 106

Senator Crossin asked:

Would you please update the figure given just before Christmas last year on the number of communities in which AHSPIA program is provided?

Answer:

Australian Hearing visited 112 locations under the AHSPIA program from 1 July 2002 to 31 March 2003.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-170

OUTCOME 6: HEARING SERVICES

Topic: COST OF AHSPIA

Hansard Page: CA 106

Senator Crossin asked:

Would you provide a year-to-date figure of the AHSPIA program?

Answer:

The expenditure on the AHSPIA program for July 2002 to March 2003 is $477,825.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-171

OUTCOME 6: HEARING SERVICES

Topic: HEARING SERVICES IN LAJAMANU IN THE NORTHERN TERRITORY

Hansard Page: CA 107

Senator Crossin asked:

Is there an Australian Hearing site in Lajamanu?

Answer:

Australian Hearing makes visits to Lajamanu twice a year.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-098

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: HEARING SERVICES TRAINING

Hansard Page: CA 103

Senator Crossin asked:

What is the exact figure provided under contract to Australian Hearing Services for training of Aboriginal Health Workers in hearing services for 2002-03?

Answer:

The total value of the training under the Contract with Australian Hearing for the delivery of the Aboriginal and Torres Strait Islander Hearing Training and Equipment Program in 2002-03 is $307,090.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-099

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: HEARING HEALTH BUDGET

Hansard Page: CA 103

Senator Crossin asked:

Provide a breakdown of the budget ($2.4m) for hearing health for 2003-04.

Answer:

The breakdown for the budget of $2.4 million for hearing health for the financial year 2003-04 is as follows:

Child Health Sites	$1,556,535
Training and Equipment (maintenance and calibration)	$378,000
Purchase and Replacement of Equipment	$160,000
Northern Territory Aboriginal Health Worker Training (Central Australia and Top End)	$231,000
Stakeholder Consultation	$60,000
TOTAL	$2,385,535

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-100

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: AUSTRALIAN HEARING SERVICES REPORT

Hansard Page: CA 105

Senator Crossin asked:

"The Aboriginal Health Worker training and audiometric equipment supply program provided by the Australian Hearing Services on behalf of the Office for Aboriginal and Torres Strait Islander Health has made a particularly strong contribution to the achievement of National Hearing Strategy outcomes."

What are the indicators of this? On what is the statement based?

Answer:

The performance measures that underpin the statement are as follows:

For provision of equipment and training by Australian Hearing:

- At least two health workers from each of those 111 Health Services identified to receive primary hearing health care training, received that training by May 1997; and
- Each Health Service to be equipped with one tympanometer, one screening audiometer and one otoscope as required by February 1997.

Of 111 eligible Aboriginal Community Controlled Health Services, 84% have fully participated in the program.

In June 2002, since the inception of the program, a total of 389 Aboriginal and Torres Strait Islander Health Workers commenced training with 306 completing both modules.

All Health Services that had completed one or two weeks training received a set of equipment.

The evaluation found that of the four components of the National Aboriginal and Torres Strait Islander Hearing Strategy 1995-99, the training and equipment component made the most significant impact, through improving awareness of ear disease and enabling screening within the sector. Aboriginal Community Controlled Health Organisations have forged linkages with Australian Hearing's audiologists, which they may have otherwise not had.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-101

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PETROL SNIFFING – REVIEW OF THREE PROGRAMS

Hansard Page: CA 108

Senator Lees asked:

For a copy of the Summary Report of the Review of Three Programs.

Answer:

A copy of the report is attached.

Review of Petrol Sniffing Programs in Central Australia

NETWORK AUSTRALIA CONSULTING PTY LTD, NOVEMBER 2002

OATSIH Summary

Background

In June 2001, the Office for Aboriginal and Torres Strait Islander Health (OATSIH) in the Commonwealth Department of Health and Ageing (the Department) commissioned Network Australia Consulting Pty Ltd to undertake an evaluation of three substance misuse programs in Central Australia for their effectiveness in reducing the prevalence of, and harm from, petrol sniffing. In the year under review, 2000-2001, OATSIH provided a total of $545,420 to these programs and other funding agencies contributed $200,000.

Terms of Reference

The overall objective of the evaluation was to:

assess the effectiveness, efficiency and appropriateness of programs (3) funded by OATSIH in reducing the prevalence and harm associated with petrol sniffing within Central Australia.

This objective was expanded during the latter stages of the review to also consider the programs in relation to other funding agencies.

The review was required to provide:

- identification and assessment of the range of interventions offered by each program, including a detailed description of the service area (i.e. both geographic and cultural) and assessment of any recent or proposed change in the scope of existing services;
- identification and analysis of relevant data and evidence concerning the effectiveness of current interventions (as identified above) in reducing the prevalence and harm associated with petrol sniffing, including the identification of those factors which influence the success or otherwise of those interventions;
- identification and assessment of staffing and other operational requirements for the delivery of **existing** services with particular reference to *duty of care*, including indicative costings to address identified gaps and deficiencies;
- recommendations for improving the appropriateness, effectiveness and sustainability of existing programs, including indicative costings for implementation of service enhancements and the development of appropriate performance indicators;
- identification and assessment of program management systems with particular reference to strategic and business planning, staff training and supervision, data collection, case management and quality assurance and collaboration with other substance misuse services/broader health services within the region; and
- a critical analysis of relevant recommendations of the report of the coronial inquest into the death of a young petrol sniffer during October 1994 and a detailed assessment of the extent to which these recommendations have (or have not) been addressed ([10]).

[10] *Summary of Principal Findings Esky Muller AKA Armstrong*, NT Coroner's Office No. A82/94

Method

The consultancy involved:

- an extensive field trip to Central Australia
- three additional visits to Alice Springs, conducted in July and September of 2001 and February 2002
- analysis of project files, statistics and other written information on each program
- semi-structured and unstructured interviews with stakeholders from remote communities, in Alice Springs and in Darwin
- relevant research and other reports on petrol sniffing
- a 'Pathways Forum' of government funding agencies held in Alice Springs in February 2002.

The programs reviewed

All three programs are aimed at substance misuse and are located in Aboriginal outstations in Central Australia. One of the programs also operates in the home community. Socio-economic indicators for the people in this region – such as life expectancy, education, health, income – indicate poor outcomes.

All communities have tried various strategies to prevent or reduce petrol sniffing, with varying degrees of success. There is ongoing concern from people in these communities to address the issue.

While the context for the programs might be similar, there are significant differences in the approaches used within each service to deal with petrol sniffing and other substance misuse.

Program A
This program operates in both the home community and an outstation and has three components involving prevention, early intervention and rehabilitation:

- activities within the home community, such as sports and a regular and frequent disco open to all young people
- foot patrols of the home community by the Program Manager
- the isolation at an outstation of young people who have been sniffing petrol. This allows the them to 'dry out', provides a deterrent and gives the community respite from the behaviours often exhibited by young people sniffing petrol – violence, noise and crime, usually breaking and entering.

On average, there are about five young people at the outstation per day. The outstation component operates for around nine months of the year and closes over the wetter months.

Program B
This program offers respite or refuge and counselling at an outstation for people with substance misuse problems. It has, in the past, been involved in festivals, events and activities aimed at strengthening communities and sharing information. More recently, it decided to shift its focus to services for women wishing to recover from violence or other abuse, while continuing to work with people with substance misuse problems.

On average, around 40 people per year use the facility. The majority of clients are self-referred from the home community and come seeking either refuge, for example from violence, or to 'dry out' and overcome a substance abuse problem, usually alcohol. Few petrol sniffers have been involved in the program in recent years.

Program C
This program is different from the other two in that participants come from more than one community and are required to learn skills such as mustering, welding, repairing bores and cars, working with horses and so on. The service has a greater emphasis on rehabilitation than the other two.

Most current program participants are referred by the courts, although some are self-referred. Many have been involved in violent crimes, often where substance abuse, usually alcohol, has been a factor. Most people are in their early 20s. Few young petrol sniffers use the program. Participants are often taken into Alice Springs for court appearances.

No data on the people at the outstation is kept by either referring agencies or the program itself. Based on the number of people currently participating in the program, together with interviews, the review estimated that the program dealt with an average of 40 clients per year.

Evaluation of the services

The three services were evaluated using criteria covering the relevant Terms of Reference:

- The impact of the program on reducing the prevalence or harm associated with petrol sniffing in the catchment area

- The impact of the program on reducing the prevalence or harm associated with substance abuse

- Support for the program from stakeholders.

- The quality of corporate governance, including community oversight, accountability and ownership of the program.

- Program management - strategic and business planning, staff training and supervision, data collection, case management, quality assurance and collaboration with other substance abuse services were considered.

- Financial management

- Compliance with Coroner Donald's recommendations.

Findings of the Review included:

Program A

This program has been successful in reducing petrol sniffing and has had a positive impact on other substance misuse. There is broad support for the program within the home community. There are problems and deficiencies in governance and program and financial management. Compliance with Coroner Donald's recommendations is incomplete ie medical assessments of clients not completed prior to admission.

Program B

Most clients at this service have had problems with alcohol misuse. The service's involvement in festivals and events have strengthened communities and had positive outcomes. The organisation recently decided to shift its focus to women recovering from violence or other abuse. There is little evidence of participation from nearby communities. There are problems and deficiencies in governance and program and financial management, but there is staff training, liaison with other agencies and strategic planning. Compliance with Coroner Donald's recommendations is incomplete ie not all those who operate the facility have appropriate first aid qualifications.

Program C

Few of the clients at this service were petrol sniffers, but the program has had a positive impact on substance misuse. There is little evidence of support and participation from nearby communities, but community-based agencies suggest it as an option to the courts. There are problems and deficiencies in governance and program management, but financial management appears adequate. Compliance with Coroner Donald's recommendations is incomplete ie this service has only partially adequate facilities in terms of communications and first aid.

Key recommendations

The following are considered to be key components of programs of this nature. There is presently some variability in the extent to which each of the programs meet these and the review recommended that they be addressed:

Health and safety of clients

- staff must hold current first aid certificates at the appropriate level
- staff should be required to ring or radio the home community or referring agency daily to confirm the ongoing safety of participants
- clients referred by an agency must be medically assessed before being taken to an outstation
- an audit of the facilities is required to identify areas where occupational health and safety provisions are inadequate.

Case management and information collection

- simple records need to be kept on each individual who attends, including name, health check status, length of stay and behaviour
- weekly statistics on the number of clients should be maintained, including names of all participants, referring agency, reasons for referral and length of stay
- data collected can be used to inform performance measures
- the confidentiality of personal information must be ensured through appropriate storage

Governance and business planning processes

- staff and management committee members should receive basic training on governance issues covering the legal, financial and reporting responsibilities of management committee members.
- the services need to develop strategic and business plans, taking into account current regional initiatives such as the *Central Australian Regional Substance Misuse Strategic Plan* [11] and the Youth Link-Up Service (YLUS).

Working together and maintaining linkages

- each agency needs to develop and maintain linkages with other agencies working in addressing petrol sniffing or other substance misuse, and stay abreast of developments
- staff should be required to allocate a proportion of time to this activity.

"Key learnings" from the review

Following the workshop between Network Australia consultants and government stakeholders (Commonwealth Department of Family and Community Services, Commonwealth Department of Health and Ageing, NT Department of Health and Community Services, Northern Territory Correctional Services, Northern Territory Police, and the Juvenile Diversionary Unit), held in February 2002, four "key learnings" for these programs were identified:

- the need for coordinated and integrated program development and delivery, at government and community levels as well as across the region
- recognition that solutions come from communities and families working in partnership with governments
- program priority should be towards enhancing life skills of individuals and families, including inter-generational learning
- there needs to be an increased focus on long-term outcomes.

[11] Central Australian Regional Indigenous Health Planning Committee, *Central Australian Regional Substance Misuse Strategic Plan,* Australian Government Publishing Service, Canberra, 2001

Implementing the recommendations

The Department will discuss with the three services/communities individually the future of each program in the light of the conclusions and recommendations of the review. These discussions will take into account the changing needs and priorities of the communities and the relative importance of petrol sniffing in services that have to date been funded to address substance misuse.

The Department will ensure that the key recommendations of the review in the areas of health and safety of clients, case management, governance and accountability are implemented by these and any similar services that may be funded in future.

The Department will bring all three services together to meet with other Central Australian organisations concerned with substance misuse. Discussions will centre on information sharing and consideration of integrating the services into a regional network with appropriate support and referral mechanisms. Other communities in the region would be encouraged to join the regional network.

In partnership with the Department of Family and Community Services (FaCS), other Commonwealth and NT government agencies and non-government agencies, the Department will work to facilitate the sustainable provision of activities for both young and working age people in remote communities. These can help prevent or divert young people from substance misuse or from starting again after a period of drying out, as well as improving well-being and forming the basis for a healthy lifestyle.

The Department will support the Central Australian Cross Border Reference Group on Volatile Substance Use in the development of an action plan to address issues of volatile substance use common to South Australia, Western Australia and the Northern Territory.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-102

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: SOCIAL AND EMOTIONAL WELLBEING

Hansard Page: CA 112

Senator Crossin asked:

How is the $6m for Emotional and Social Wellbeing for 2002/03 divided by States and Territories?

Answer:

	Amount
National Funding	$1,023,815
Queensland	$1,165,746
South Australia	$630,794
Victoria	$1,045,547
New South Wales	$870,677
Western Australia	$429,184
Tasmania	$143,037
Northern Territory	$668,038
TOTAL:	$5,976,838

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-103

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: EYE HEALTH

Hansard Page: CA 118-119

Senator Crossin asked:

(a) You are going to take on notice the amount of unexpended funds that were carried forward into each year? (what was estimated and then actuals up until this year and explain the differences)
(b) You provided me with a number of initiatives (last November). What amount of money do you provide either totally for or towards those initiatives for the 2003-04 year?

Answer:

(a)

Year	**Estimated $m's**	**Actual $m's**	**Reason for Difference**
2000-01	3.39 original est 3.33 revised est (Feb 2001 Senate Estimates).	2.54	Delays in purchasing: – Equipment (WA and NT). – NT training unexpended. – TAS allocation unexpended (pending commencement of program in Tas).
2001-02	3.9	3.48	Delays due to: – Need for second tender process for the Implementation Review; – Delay in Coordinator's Workshop (pending commencement of Review); – Equipment (part of WA alloc); – NT training was unexpended; and – TAS unexpended equipment (pending commencement of program in Tas).

(b)

- A contracted payment totalling $200,000 will be made for the Australian Indigenous Health Infonet in 2003-04.
- At the time of writing (27 June 2003) the exact allocation for the Patient Information and Recall System (PIRS) in 2003-04 has not yet been determined.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-104

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: WORKFORCE FUNDING

Hansard Page: CA 121

Senator Crossin asked:

What is the proposed workforce funding allocation amount for 2004-05?

Answer:

At the time of writing (23 June 2003) the exact allocation for OATSIH workforce funding for 2003-04 has not yet been determined but will be at least $9.6m. The exact allocation for 2004-05 will not be determined until June 2004 but we would expect it to be no less than $9.6m.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-105

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: INDIGENOUS HEALTH WORKERS

Hansard Page: CA 121

Senator Crossin asked:

Last year you provided me with the figures of Aboriginal health workers employed on CDEP. You only had 2001 census figures.

(a) Is there anyway you can get more recent figures than that?

(b) Can ATSIC actually provide you with the number of health workers employed on CDEP for 2002?

Answer:

(a) There is no more recent data.

(b) ATSIC do not collect this data.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-106

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM

Hansard Page: CA 122

Senator Crossin asked:

At the last estimates you provided me with the year to date 2002-03 expenditures on PHCAP by specific site. It was in response to question on notice E03-114. Can you update that table for me?

Answer:

	2002-03 PHCAP funding expenditure - Recurrent (including one-offs) to week of 23 June 2003	**2002-03 PHCAP allocations for agreed capital works (construction in progress)**	**Budgeted amounts 2002-03**	**Agreed estimated population levels – (Indigenous Australians)**
Northern Territory wide	$281,480		$329,000	
Tiwi	$1,326,769	$2,272,727	$3,824,499 (1) (2)	2,000
Katherine West	$2,623,647		$2,978,727 (2)	3,060
Sunrise	$200,000		$450,000 (2)	2,275
Anmatjera	$39,710	$3,640,521	$3,733,856 (1)	1,464
Eastern Arrernte-Alyawarra	$68,214	$2,312,583	$2,427,676 (1)	877
Northern Barkly	$63,027	$624,750	$718,341(1)	821
Warlpiri	$61,157	$2,610,960	$2,702,681 (1)	1,404
Luritja Pintupi	$72,771	$2,549,635	$2,644,516 (1)	1,298
South Australia				
Northern Metro	$779,482	$491,460	$1,270,942 (1)	4,115
Wakefield	$59,043	$344,850	$403,893 (1)	758
Hills Mallee Southern	$0		$0	1,390
Port Augusta sub-region	$274,000	$74,000	$348,000	3,068
Riverland	$72,350		$72,350	623

	2002-03 PHCAP expenditure to week of 23 June 2003	2002-03 PHCAP allocations for agreed capital works (construction in progress)	Budgeted amounts 2002-03	Agreed estimated population levels – (Indigenous Australians)
Queensland				
Queensland wide	$13,000		$13,000	
Atherton/Croydon	$9,230		$36,000	4,180
Inland/Mt Isa	$9,230		$36,000	4,315
Central Highlands	$9,230		$36,000	1,688
Torres	$50,000		$50,000	6,850
Near South West	$9,230		$36,000	1,210
Capacity Building sites QLD				
Gulf	$165,000		$165,000	3,796
Cook	$402,000		$551,000	3,240
NSW				
Wilcannia	$696,450		$696,450	1,000
Western Australia				
Perth/Bunbury	$2,726,901		$2,733,137 (2)	1990
TOTAL	**$10,011,921**	**$14,921,486**	**$26,257,068**	**51,471**

(1) includes capital allocations for works currently underway.
(2) Final 2002-03 payment to services to be made by 30 June 2003

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-108

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PRIMARY HEALTH CARE ACCESS PROGRAM - TRAINING

Hansard Page: CA 124

Senator Crossin asked:

Could you provide me figures showing how much of the $33.5m for this financial year has been dedicated to training, and how much you intend to provide out the $54.7m towards training? If you can, where that training dollar is being targeted in each State and Territory?

Answer:

Under PHCAP a high priority is given to funding capacity development for community controlled organisations that take on service delivery roles – including training and other management support activities.

It is not possible however, to identify all the funding that was used specifically for training in 2002-03. Allocations to organisations funded under PHCAP may include funds for capacity building (which may include training for staff, board and community members), board costs (which may include financial and management training) as well as funds for health service development and delivery. Organisations funded under PHCAP draw on these allocations to conduct training as the need arises.

In 2002-03, approximately $1,384,670 was allocated for capacity building and board costs, which would include training requirements. On a state by state basis this breaks down to:

NT	$543,446
SA	$284,500
NSW	$160,000
WA	$231,724
QLD	$165,000

Of the $54.7 million in 2003-04, it is not possible to quantify the exact amounts that would be used for training.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-107

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: MIWATJ HEALTH ABORIGINAL CORPORATION

Hansard Page: CA 122

Senator Crossin asked:

(a) Exactly when was the last time they reported to you and when was the last time financial audited reports were presented?
(b) What consultants were employed by Miwatj in the last 18 months, who they were and the amounts that were paid to each of those consultants in the last 18 months. Has each of those consultants acquitted those funds and, if they do have to, who has and who has not?
(c) I would also like to know how OATSIH assesses the performance of that Aboriginal health organisation?

Answer:

(a) The report from Miwatj Health Aboriginal Corporation for the quarter ending 31 March 2003 was received on 9 May 2003. The audited financial statements for 2001-02 were submitted on 12 September 2002.
(b) The provision of information relating to consultants employed by Miwatj Health Aboriginal Corporation in the last 18 months and the amounts that were paid to each of those consultants in the last 18 months is a matter for the consideration of the Board of Miwatj Health Aboriginal Corporation, not the Department of Health and Ageing.
(c) The performance of Miwatj Health Aboriginal Corporation is assessed by its quarterly and audited annual reports against the criteria set out in its funding agreement with OATSIH and by regular field visits by Departmental staff.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-254

OUTCOME 7: ABORIGINAL AND TORRES STRAIT ISLANDER HEALTH

Topic: PROGRAM UNDERSPENDS

Written Question on Notice

Senator McLucas asked:

Please provide explanations for the following apparent underspends for 2002-03:

		2002-03 Budget Estimate	2002-03 Estimated Actual
(a)	Petrol sniffing diversion projects	$400,000	$261,035
(b)	Infrastructure to support the Development and Operations of High Quality Health Care Services	$18,500,000	$14,954,000

Answer:

(a) Under this program, funding totalling $1m has been allocated over three years to three projects in Central Australia and the Top End.

There has been some under-expenditure in two of these projects in 2002/2003 for a number of reasons including staff turnover and the slow start up of one of the projects as a result of the need to consult extensively with a range of remote communities.

However, funding is committed under contracts with the three services and the Department will continue to work with each community to ensure that projects are implemented in accordance with the contracts.

(b) The split between *Services in Aboriginal and Torres Strait Islander Communities* and *Infrastructure to Support the Development and Operations of High Quality Health Care Services to Aboriginal and Torres Strait Islander Peoples* is established at Budget time. Funding for services is provided to organisations or State/Territory governments for direct services to Aboriginal and Torres Strait Islander peoples. Infrastructure funding covers activities which enhance or strengthen the delivery of services to Aboriginal and Torres Strait Islander peoples.

The difference between the estimated figure and the budget figure indicates that a smaller amount was required in infrastructure related activities. This should not however result in a significant underspend for the program as funding for services has increased to offset this underspend in infrastructure. As program elements mature, more is spent on service delivery compared with infrastructure which usually involves development activities.

SENATE ESTIMATES HEARINGS JUNE 2003 - 30% REBATE

Additional Information on Special Appropriation - 30% Rebate – Budget Estimates Revision

Total Cost of the Rebate

(Includes outlays administered through the Department of Health and Ageing and payments made through the Australian Taxation Office)

Year	2002-03 Additional Estimates (excluding contingency reserve)	2003-04 Budget Estimates (excluding contingency reserve)
2002-03	2,264	2,297
2003-04	2,285	2,445
2004-05	2,286	2,466
2005-06	2,286	2,466
2006-07	2,286	2,467
2007-08	2,286	2,467

Disaggregation of Total Cost of the 30% Rebate Excluding Premium Growth

	2002-03	2003-04	2004-05	2005-06	2006-07
Total estimated accrual	2,297	2,445	2,466	2,466	2,467
Accrual Tax Revenue	168	181	193	193	193
Accrual Outlays	2,129	2,264	2,274	2,273	2,274

Second Tier Day Hospital Facilities' contracts with major health funds as at May 2003

Facility approved for second tier	Contract with MPL	Contract with MBF	Contract with HCF	Contract with AHSA	Contract with NIB	Contract with BUPA (HBA)
Aesthetic Day Surgery	MPL		HCF	AHSA	NIB	BUPA
Albury Day Surgery	MPL	MBF	HCF	AHSA		BUPA
Ballina Day Surgery	MPL	MBF	HCF	AHSA	NIB	
Broadmeadow Day Surgery	MPL		HCF	AHSA	NIB	BUPA
Buderim Gastroenterology Centre			HCF	AHSA	NIB	BUPA
Chasely Day Theatre	MPL		HCF	AHSA	NIB	BUPA
Colin Street Day Surgery				AHSA		
Griffiths Road Day Procedure Centre			HCF			
Logan Endoscopy Services			HCF	AHSA		
Maroubra Day Surgery	MPL		HCF	AHSA	NIB	BUPA
Montserrat Day Hospital (Indooroopilly)		MBF	HCF	AHSA		BUPA
Montserrat Day Hospital (Spring Hill)			HCF	AHSA		BUPA
Orange Day Surgery Centre			HCF	AHSA		
Pacific Day Surgery Centre	MPL			AHSA	NIB	BUPA
Pendlebury Clinic			HCF	AHSA		
Pittwater Day Surgery			HCF	AHSA	NIB	BUPA
QFG Day Theatres	MPL	MBF	HCF	AHSA	NIB	BUPA
Randwick Day Surgery	MPL		HCF	AHSA		
Roderick Street Day Surgery				AHSA		
Solander Day Surgery				AHSA		
Sydney IVF Clinic			HCF	AHSA	NIB	
Sydney IVF – Liverpool			HCF	AHSA		
Terrace West Endoscopy Centre	MPL			AHSA		
The Eye Institute	MPL	MBF	HCF	AHSA		BUPA

Second Tier Private Hospitals' contracts with major health funds as at May 2003

Facility approved for second tier	Contract with MPL	Contract with MBF	Contract with HCF	Contract with AHSA	Contract with NIB	Contract with BUPA (HBA)
Cambridge Private Hospital				AHSA		
Malvern Private Hospital	MPL			AHSA	NIB	BUPA
Maryvale Private Hospital	MPL			AHSA	NIB	BUPA
Mayo Private Hospital	MPL	MBF	HCF	AHSA	NIB	BUPA
Poplars Private Hospital	MPL	MBF	HCF	AHSA	NIB	
South Pacific Private Hospital				AHSA		
Sportsmed SA Hospital	MPL		HCF	AHSA	NIB	
St Luke's Hospital Complex	MPL	MBF	HCF	AHSA	NIB	
Vaucluse Private Hospital *Non-rehabilitation patients only*				AHSA		
Wolper Jewish Hospital	MPL	MBF	HCF	AHSA	NIB	BUPA

Attachment C

Rural and Regional Default Benefit

Day Hospital Facilities potentially eligible for the new Rural and Regional Default Benefit

NAME	ADDRESS	SUBURB	STATE	P/CODE	BEDS
Ballarat Day Procedure Centre	1119-1123 Howitt Street	Ballarat	VIC	3350	26
Ballina Day Surgery	46 Tamar Street	Ballina	NSW	2478	10
Bowral Diagnostic Centre	2 Holmhale St	Bowral	NSW	2576	7
Buderim Gastroenterology Centre	139 King Street	BUDERIM	QLD	4556	2
Cairns Day Surgery	156-160 Grafton St	Cairns	QLD	4870	14
Cairns Surgical Centre	92 Pease Street, Manoora	Cairns	QLD	4870	4
Calvary Day Procedure Centre	329, 331, 333 Edward Street	WAGGA WAGGA	NSW	2640	28
Coffs Harbour Day Surgical Centre	69 Albany Street	Coffs Harbour	NSW	2450	4
Hastings Day Surgery	Cnr Parker & Savoy Streets	Port Macquarie	NSW	2444	6
Insight Clinic Day Procedure Centre	441 Guinea Street	Albury	NSW	2640	8
Lismore Private Day Surgery	77 Uralba Strret	Lismore	NSW	2480	8
Mater Misericordiae Day Unit	1 Wellington Street	MACKAY	QLD	4740	4
Orange Day Surgery Centre	60-62 McNamara Street	ORANGE	NSW	2800	14
Orange Eye Centre	269 Lords Place	ORANGE	NSW	2800	5
Port Macquarie Sleep Disorders Laboratory and Endoscopy Clinic	Suite 4/32 Morton Street	PORT MACQUARIE	NSW	2444	2
Riverina Cancer Care Centre	Calvary Hospital, Hardy Avenue	WAGGA WAGGA	NSW	2650	9
Riverina Cardiovascular and Physiology Centre	Calvary Hospital, Hardy Avenue	WAGGA WAGGA	NSW	2650	7
Solander Day Surgery	182 Grafton Street	CAIRNS	QLD	4870	3
St Andrew's Toowoomba Renal Dialysis Unit	266A North Street	TOOWOOMBA	QLD	4350	6
Stanthorpe Endoscopy Unit	43 Railway Parade	STANTHORPE	QLD	4380	1
Taree Community Dialysis Centre	56 Chatham Avenue	TAREE	NSW	2430	7
The Eye Hospital	262 Charles Street	LAUNCESTON	TAS	7250	2
Toowoomba Day Surgical Centre	18 Scott Street	TOOWOOMBA	QLD	4350	5
Wagga Endoscopy Centre	50 Best Street	WAGGA WAGGA	NSW	2650	5
Western Plains Day Surgery	62 Windsor Parade	DUBBO	NSW	2830	12

Private Hospitals with 50 or less beds potentially eligible for the new Rural and Regional Default Benefit

NAME	ADDRESS	SUBURB	STATE	P/CODE	BEDS
Albany Hospice	322 Princess Royal Drive	Albany	WA	6330	4
Allora District Co-op Hospital	Darling Street	Allora	QLD	4362	47
Ardrossan Community Hospital Inc	37 Fifth Street	Ardrossan	SA	5571	17
Armidale Private Hospital	Armidale Campus/Rusden St	Armidale	NSW	2350	36
Ballan and District Soldiers Memorial Hospital	33 Cowie Street	Ballan	VIC	3342	6
Bega Valley Day Surgery Centre and Private Hospital	31 Parker Street	Bega	NSW	2550	12
Busselton Hospice	Craigh Street	BUSSELTON	WA	6280	2
Chiltern and District Bush Nursing Hospital	Main Street	Chiltern	VIC	3683	14
Clifton Co-operative Hospital	Norman Street / PO Box 1	Clifton	QLD	4361	12
Cobden District Health Services	5 Victoria Street	Cobden	VIC	3266	4
Coffs Harbour Sleep Disorder Clinic Private Hospital	29 Park Beach Road	Coffs Harbour	NSW	2450	3
Cooloola Community Private Hospital	78-82 Channon Street	Gympie	QLD	4570	40
Crows Nest and District Co-op Hospital	8 Grace Street	CROWS NEST	QLD	4355	16
Eden Private Health Care Centre	50 Maple Street	COOROY	QLD	4563	36
Euroa Hospital	Kennedy Street	Euroa	VIC	3666	20
Hamley Bridge Memorial Hospital	19 Albert Street	Hamley Bridge	SA	5401	25
Heyfield Hospital	Tyson Road	Heyfield	VIC	3858	13
Keith and District Hospital	PO Box 282, Hill Avenue	Keith	SA	5267	32
Killarney and District Memorial Hospital	Cedar Street	Killarney	QLD	4373	18
Mallala Community Hospital	Aerodrome Road	MALLALA	SA	5502	22
Maryvale Private Hospital	McDonald Street	MORWELL	VIC	3840	45
Mater Hospital Yeppoon	Cnr Cliff & Hutton Streets	YEPPOON	QLD	4703	18
Mater Misericordiae Private Hospital Gladstone	Rossella Street	GLADSTONE	QLD	4680	30
Mildura Private Hospital	220-228 Thirteenth Street	MILDURA	VIC	3500	50

Mount Gambier Private Hospital	276-300 Wehl Street North	MOUNT GAMBIER	SA	5290	20
Murray Valley Private Hospital	Cnr Pearce & Nordsvan Drive	WODONGA	VIC	3690	45
Nagambie Hospital	22 Church Street	NAGAMBIE	VIC	3608	15
Neerim District Soldiers Memorial Hospital	Main Road	NEERIM	VIC	3831	34
North West Private Hospital	Brickport Road	BURNIE	TAS	7320	48
Northern Yorke Peninsula Private Hospital	Ernest Terrace	WALLAROO	SA	5556	6
Peel Health Campus	110 Lakes Road	MANDURAH	WA	6210	20
Pioneer Valley Private Hospital	Norris Road	NORTH MACKAY	QLD	4740	39
Pittsworth and District Hospital Friendly Society	10 Weale Street	PITTSWORTH	QLD	4356	39
Riverland Private Hospital	Maddern Street	BERRI	SA	5343	21
Rosebery Community Hospital	Murchison Highway	ROSEBERY	TAS	7470	10
Sealake and District Hospital	33-43 McCelland Street	SEA LAKE	VIC	3533	13
South Burnett Community Private Hospital	31 Markwell Street	KINGAROY	QLD	4610	18
South Coast Community Hospital Inc	Rex Hutchesson Wing, Sth Coast District Hosp. , Bay Road	VICTOR HARBOUR	SA	5211	18
St Vincent's Private Hospital	Gorman Hill Road	BATHURST	NSW	2795	35
Walwa Bush Nursing Hospital Inc	Murray River Rd (Main Street)	WALWA	VIC	3709	10
Wangaratta Private Hospital	134-150 Templeton Street	WANGARATTA	VIC	3677	24
Warley Hospital	12 Warley Avenue	COWES	VIC	3922	13
Yackandandah Bush Nursing Hospital	20 Isaacs Avenue	YACKANDANDA	VIC	3749	17
Yeoval Community Hospital	Lord Street	YEOVAL	NSW	2868	7

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-087

OUTCOME 8

Topic: PRIVATE HEALTH INSURANCE REBATE

Senator Nettle asked:

How much is the Private Health Insurance Rebate estimated to cost in 2003/2004?

(a) Does this include the additional cost from the Medicare package safety net for non-concessionary patients?

(b) What proportion and dollar value of the rebate subsidises ancillary insurance cover?

(c) Of this, what proportion and dollar value of the rebate subsidises dental services?

(d) How does this compare with the Commonwealth's contribution to dental services for Veterans and towards state and territory dental schemes?

(e) Does the Government have a projected target for private health insurance, eg a particular proportion of the population?

Answer:

(a) This information was tabled during the Committee proceedings on 5 June 2003 by Dr Morauta. Please see Hansard page CA491.

(b) Yes.

(c) The exact amount relating to ancillary services is not recorded as many policies contain both hospital and ancillary cover as a package, rather than separate items. However the amount can be inferred from the fact that 30.1% of all benefits paid in 2001-2002 were for ancillary services. On this basis the dollar value of the rebate attributed to ancillary cover in 2001-2002 was $650 million.

(d) 15.7% of all benefits paid in 2001-2002 were for dental services. The dollar value of the 30% Rebate that can be attributed to dental services was $333 million.

(e) The Department of Veterans' Affairs estimates their expenditure on dental services in 2003-04 to be $75,274,000. The states and territories have responsibility for determining their priorities in relation to the provision of dental services. There is no specified dental component of the funding provided to the states and territories by the Commonwealth under the Australian Health Care Agreements.

(f) No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-088

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: MEDICARE SAFETY NET PACKAGE

Written Question on Notice

Senator Nettle asked:

The Portfolio Budget Statement (pg 210) says that the department will be working with private health funds in 2003-04 to develop the out-of-hospital private health insurance product that is part of the Medicare package.

(a) What was the basis of the Prime Minister's claim that it would cost no more than one dollar a week?

(b) Does the Department agree with this estimated premium cost?

(c) Have you seen a report in the Sydney Morning Herald, which casts doubt on the foreshadowed premium because very few people (around 30,000) a year non-concessionary patients will incur this level of debt?

(d) As people will be able to claim 100% of their out-of-pocket expenses over $1,000, why won't this simply drive up the cost of insurable health services?

(e) What steps does the Government intend to take to ensure this won't happen?

(f) Given the steady high increase in private health insurance premiums in the past few years, what measures is the Government proposing to stop the same thing happening to this form of private health insurance?

Answer:

(a) The Prime Minister’s claim was based upon actuarial assessment of the likely achievable fair value of the out-of-hospital insurance.

(b) Yes.

(c) The Department is aware of the report. However, the fact that people do not expect to make a claim on insurance does not mean that they will not purchase insurance.

(d) The majority of doctors are caring and compassionate people with the best interests of their patients at heart and they will not take advantage of people with severe health needs. Nevertheless, the Health Insurance Commission will be monitoring industry practices and if concerns are identified the Government will consider taking action. If doctors do raise their charges, the patient will be required to pay the fee upfront and then claim it back from her or his health fund. Patients will therefore have a strong interest in monitoring doctors charges and questioning if a doctor charges excessively.

(e) The HIC will monitor charging patterns of general practitioners, both under the $500 concessional safety net for concessional patients and the Private Health Insurance safety net product. If the HIC detects evidence of collusion, it will take appropriate investigatory action. If it emerges that simple overcharging is an issue, a further policy response will be considered.

(f) The legislative powers already exist to contain premium increases. Under subsection 78(4) of the *National Health Act 1953* the Minister is empowered to declare that a proposed premium increase will not come into operation if the proposed increase does not meet the criteria.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-089

OUTCOME 8: OUTCOME THROUGH PRIVATE HEALTH

Topic: PRIVATE HEALTH INSURANCE

Written Question on Notice

Senator Webber asked:

What action is being taken to ensure that private health insurance provides effective cover for emergency hospital treatment? What are the reasons for not ensuring members of private health insurance are able to use their private fund cover in an emergency?

Answer:

Private health insurance hospital tables provide benefits for all admitted patients whether this is in an emergency situation or on an elective basis. Benefits are not paid from hospital tables for procedures covered by the Medicare Benefits Schedule that are provided in accident and emergency departments as the patient is not an admitted patient of the hospital. This policy has been in existence for many years.

There is nothing stopping funds from offering benefits from their ancillary tables for procedures provided in accident and emergency departments that are not covered by the Medicare Benefits Schedule. However, a fund's willingness to pay benefits from its ancillary table or not, is entirely a matter for the fund as the Government does not interfere in this area other than it has agreed with the health insurance industry that ancillary tables deliver direct health benefits to members and that the tables be community rated.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-133

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: 30% REBATE

Hansard Page: CA 482

Senator McLucas asked:

Can you provide the breakdown, financial year by financial year, of the total actual spending to date on the 30 per cent private health insurance rebate administered by the Department of Health and Ageing and the Treasury?

Answer:

The total actual spending to date on the 30% Rebate has been as follows:

	Health & Ageing	**Treasury**
1998-99	$ 784 million	
1999-00	$1,412 million	$121 million
2000-01	$1,930 million	$197 million
2001-02	$1,977 million	$182 million

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-134

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: PHI ADVERTISING

Hansard Page: CA 482

Senator McLucas asked:

What is the total estimated spending by the Department for the financial year 2002-03 for advertising on private health insurance?

Answer:

The Department has spent $1,574.76 on advertising for private health insurance purposes in 2002-03. This was for the recruitment of a suitably qualified consultant to review the operational of legislative changes supporting the funding of outreach services by health insurance funds.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-135

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: LIFESTYLE BENEFITS

Hansard Page: CA 483

Senator McLucas asked:

Could I get a copy of the letter from the AHIA to the Minister that canvasses the ACCC action?

Answer:

The AHIA has agreed to release their letter to the Committee. See Attachment A.

ATTACHMENT
EO-133

Australian Health Insurance Association Ltd

(ABN 35 008 621 994 - A COMPANY LIMITED BY GUARANTEE - INCORPORATED IN THE A.C.T.)

PRESIDENT:
Mr Terry Smith MBE RFD ED

CHIEF EXECUTIVE
Mr Russell Schneider

NATIONAL SECRETARIAT:
4 Campion Street
Deakin ACT 2600

Telephone: (02) 6285 2977
Facsimile: (02) 6285 2959
Email: admin@ahia.org.au

Minister for Health and Aged Care
13 MAY 2003
Comments
Re: MO3001302

MO3004981

RECEIVED
13 MAY 2003

9 May 2003

Senator the Hon Kay Patterson
Minister for Health & Ageing
Suite MG48 - Parliament House
CANBERRA ACT 2600

Dear Minister

You will recall I wrote to you on 7 February 2003 about the Australian Health Insurance Association's belief that ancillary benefits should be removed from items normally purchased for the purpose of sport, recreation or entertainment.

In that letter, I noted that AHIA would be seeking guidance from the Australian Competition and Consumer Commission (ACCC) on how funds may act together to remove such benefits, without contravening those provisions of the Trade Practices Act relating to collusion.

AHIA has had discussions with the ACCC. In the course of these discussions, it has become apparent that it will take the ACCC a minimum of 3 months to complete its deliberations, followed by a 12-month phase-out period if the ACCC agrees that the funds may act in concert to withdraw these products. As far as we are able to ascertain, there is no avenue by which the process can be expedited, nor any certainty of outcome.

In AHIA's view, the passage of such a significant period of time between the announcement of our intention, and our ability to effect it, is most regrettable. It has a number of undesirable consequences and would be inconsistent with community expectations. For example, those funds that acted promptly to withdraw the items are now at a disadvantage, relative to those funds which must now await the outcome of the ACCC's deliberations, because they can no longer attract members by offering benefits for these items. For those funds that still offer the product, the risk is of an inundation of claims in respect of these items as the close-off date approaches.

Given our common desire to see timely action taken to allow funds to remove benefits for these items, AHIA would ask that you consider use of your regulatory power to effect the change. There are several options you may wish to consider, including making a condition of registration that funds not offer ancillary benefits for items primarily purchased for the purpose of sport/recreation/entertainment, but allow them to continue to offer benefits for such things as gym membership required as part of a fund approved health management program, including but not limited to weight loss; or a determination under s73B, which lists ancillary benefits.

If you agree, I would propose to contact your Department with a view to proceeding with a regulatory approach to discontinuing benefits for such items at the earliest opportunity with a view to their cessation, consistent with community expectations, by 30 June 2003.

Russell S

Yours sincerely

RUSSELL SCHNEIDER

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-137

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: HEALTH FUND PRODUCT CHANGES

Hansard Page: CA484

Senator McLucas asked:

Could you identify those products what have actually changed in the intervening period of time?

Answer:

The following health funds have notified the Department about changes to their products since 13 February 2003. Their product changes are listed:

Fund	Description of change	Date of effect
BUPA	• Hospital table excesses increased • New co-payments applied to some hospital tables • Various increases and decreases applied to ancillary table benefits (chiropractic, hearing aids, spectacles etc.)	31 March 2003
Medibank Private	• Increases and decreases applied to dental and optical benefits.	31 March 2003
Mildura Hospital Ltd	• Increases in hospital default benefits and ancillary benefits (prostheses).	1 April 2003
HBF of WA	• increase in ancillary benefits (dietetics, occupational therapy etc.)	1 April 2003
QLD Country Health	• Reduction in ancillary benefits (orthodontic, podiatry, Xrays)	1 April 2003
Grand United Corporate	• Changes to definitions, corrections and updates.	1 April 2003
Grand United Health	• Increases in various hospital and ancillary benefits (dental etc.) • Withdrawal of 2 ancillary tables • Introduction of new ancillary table	1 April 2003
HIF of WA	• Changes to ancillary benefits waiting	1 April 2003

	periods (dental, optical, monitors etc.)	
Westfund	• Introduction of baby bonus • Waiting periods increased for some ancillary items (contact lenses, orthopedic shoes etc.)	1 April 2003
Cessnock District Health	• Ancillary benefits increased (acupuncture, various therapies and dental items)	1 April 2003
Phoenix Health	• Amendments to Definitions • Increases in benefits (dental)	1 April 2003
Teachers Federation Health	• Increases in ancillary benefits (optical, natural therapies, podiatry etc.)	1 April 2003
Druids, Vic	• Change to hospital table to provide more flexibility to members	1 April 2003
MBF	• Reopen hospital table • convert state based hospital product to national • Product rationalisation	1 April 2003
IOOF	• Increases to hospital table excesses • Increases in ancillary benefits (dental, spectacles, health management appliances etc.)	1 April 2003
Australian Unity	• Dental benefit increases	1 April 2003
Manchester Unity	• Various changes to ancillary benefits (eg. removal of fitness benefits etc.)	1 April 2003
GMHBA	• Increased hospital benefits • Increased ancillary benefits across a wide range of items	1 April 2003
Australian Health Management Group	• Minimal changes across the range of ancillary benefits	1 April 2003
ACA	• Dental benefit increases	1 April 2003
Health Care Insurance	• New hospital table • New ancillary benefits and increases to others (chiropractic, natural therapy etc.)	1 April 2003
NRMA	• Hospital product co-payment and excess increases • Ancillary benefits removed (iridology, sports shoes) • Weight loss classes and quit smoking courses added to ancillary benefits.	1 April 2003
Health-Partners	• Ancillary benefits increased (chiropractic, naturopathy, acupuncture)	1 April 2003
Defence Health	• Increased ancillary benefits (dental, chiropractic, naturopathy, acupuncture)	1 April 2003
HBF of WA	• Removal of ancillary benefits (rapid weight loss program, pain management centre)	1 April 2003
Transport Friendly	• Increased optical and dental limits	1 April 2003

MBF	• Closure of QLD Ambulance Cover	12 April 2003
Federation Health	• Increased ancillary benefits (dental, optical, chiropractic, naturopathy, acupuncture etc.)	1 May 2003
Druids, NSW	• Ancillary benefits have increased (Speech Therapy, Chiropractic and Osteopathy, Dental and Podiatry) •	15 May 2003
IOR	• Addition of ancillary items under optical, dental, physiotherapy, chiropractic/osteopathy, psychology services and hearing aids.	14 May 2003
Healthguard	• Reduced pharmaceutical benefits	1 June 2003

The following health funds have also notified the Department of changes to their products. However, as the proposed changes have not yet come into effect, details are commercial-in-confidence:

- Westfund Ltd
- SA Police Employees' Health Fund Inc.
- United Ancient Order of Druids Friendly Society Ltd.
- Medibank Private Limited
- GMHBA Limited
- NIB Health Funds Limited

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-138

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: ACCESS TO BEDS

Hansard Page: CA 484

Senator McLucas asked:

What I am looking for is whether or not the results of that audit were made available to the department and if they were, if it is possible for the committee to have a copy of the report.

Answer:

The Australian Health Insurance Association (AHIA) has advised the Department that an audit as such was not undertaken. The AHIA has advised that all members for the association, as well as the members of the Health Insurance Restricted Membership Association of Australia, were requested to review their documentation to see if there was any record of problems with their members being denied access to private hospitals. The AHIA has reported to the Department that no instances were reported.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-139

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: ACCESS TO BEDS

Hansard Page: CA 485

Senator McLucas asked:

Could we have a list of the membership of that taskforce, please?

Answer:

The Private Hospital Access Taskforce has one member from each of the following organisations:

Department of Health and Ageing, Australian Private Hospitals Association, Catholic Health Australia, Mayne Health, Australian Health Insurance Association, Australian Health Service Alliance, Australian Medical Association, Health Insurance Restricted Membership Association of Australia and the Consumer Health Forum.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-140

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: ACCESS TO BEDS

Hansard Page: CA 485

Senator McLucas asked:

There is no report because it is an ongoing committee, but it might be informative to have a look at the minutes of that task force.

Answer:

The Private Health Access Taskforce is an ongoing working group involving many external stakeholders. The Minutes from the meetings are not available for public release.

The main result to date of the Taskforce's work was the establishment in June 2002 of a 24-hour Access Report Line by the Australian Health Insurance Association to allow any doctor who had experienced a difficulty in admitting a privately insured patient to a private hospital to report it. The arrangements included direct links to health funds to allow them to endeavour to assist if this was practical.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-142

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH INSURANCE

Topic: SECOND TIER

Hansard Page: CA 490

Senator McLucas asked:

Perhaps you could take on notice to provide a list of private hospitals in RRMAs 3 to 7.

Answer:

Using the latest information available to the Department, as at the end of May 2003, the following tables identify the private hospitals and day hospital facilities that are located within the Rural, Remote and Metropolitan Areas (RRMA) Classification System zones 3 to 7.

Rural and Regional Default Benefit

Day Hospital Facilities Potentially Eligible For The New Rural And Regional Default Benefit

NB: Those day hospital facilities marked with * are currently approved for second tier benefits.

NAME	ADDRESS	SUBURB	STATE	P/CODE	BEDS	RRMA
*Albury Day Surgery	PO Box 970	West Albury	NSW	2640	31	3
Ballarat Day Procedure Centre	1119-1123 Howitt Street	Ballarat	VIC	3350	26	3
*Buderim Gastroenterology Centre	139 King Street	Buderim	QLD	4556	2	3
Cairns Day Surgery	156-160 Grafton St	Cairns	QLD	4870	14	3
Cairns Surgical Centre	92 Pease Street, Manoora	Cairns	QLD	4870	4	3
Calvary Day Procedure Centre	329, 331, 333 Edward Street	Wagga Wagga	NSW	2640	28	3

Day Hospital Facilities Potentially Eligible For The New Rural And Regional Default Benefit (Continued)

Hastings Day Surgery	Cnr Parker & Savoy Streets	Port Macquarie	NSW	2444	6	3
Insight Clinic Day Procedure Centre	441 Guinea Street	Albury	NSW	2640	8	3
Lismore Private Day Surgery	77 Uralba Street	Lismore	NSW	2480	8	3
Mater Misericordiae Day Unit	1 Wellington Street	Mackay	QLD	4740	4	3
*Orange Day Surgery Centre	60-62 McNamara Street	Orange	NSW	2800	14	3
Orange Eye Centre	269 Lords Place	Orange	NSW	2800	5	3
Port Macquarie Sleep Disorders Laboratory and Endoscopy Clinic	Suite 4/32 Morton Street	Port Macquarie	NSW	2444	2	3
Riverina Cancer Care Centre	Calvary Hospital, Hardy Avenue	Wagga Wagga	NSW	2650	9	3
Riverina Cardiovascular and Physiology Centre	Calvary Hospital, Hardy Avenue	Wagga Wagga	NSW	2650	7	3
*Solander Day Surgery	182 Grafton Street	Cairns	QLD	4870	3	3
St Andrew's Toowoomba Renal Dialysis Unit	266A North Street	Toowoomba	QLD	4350	6	3
The Eye Hospital	262 Charles Street	Launceston	TAS	7250	2	3
Toowoomba Day Surgical Centre	18 Scott Street	Toowoomba	QLD	4350	5	3
Wagga Endoscopy Centre	50 Best Street	Wagga Wagga	NSW	2650	5	3
Western Plains Day Surgery	62 Windsor Parade	Dubbo	NSW	2830	12	3
*Ballina Day Surgery	46 Tamar Street	Ballina	NSW	2478	10	4
Coffs Harbour Day Surgical Centre	69 Albany Street	Coffs Harbour	NSW	2450	4	4
Taree Community Dialysis Centre	56 Chatham Avenue	Taree	NSW	2430	7	4
Bowral Diagnostic Centre	2 Holmhale St	Bowral	NSW	2576	7	5
Stanthorpe Endoscopy Unit	43 Railway Parade	Stanthorpe	QLD	4380	1	5

Private Hospitals With 50 Or Less Beds Potentially Eligible For The New Rural And Regional Default Benefit

NB: The hospital marked with * is currently approved for second tier benefits.

NAME	ADDRESS	SUBURB	STATE	P/CODE	BEDS	RRMA
Murray Valley Private Hospital	Cnr Pearce & Nordsvan Drive	Wodonga	VIC	3690	45	3
Pioneer Valley Private Hospital	Norris Road	North Mackay	QLD	4740	39	3
Albany Hospice	322 Princess Royal Drive	Albany	WA	6330	4	4
Armidale Private Hospital	Armidale Campus/Rusden St	Armidale	NSW	2350	36	4
Coffs Harbour Sleep Disorder Clinic Private Hospital	29 Park Beach Road	Coffs Harbour	NSW	2450	3	4
*Maryvale Private Hospital	McDonald Street	Morwell	VIC	3840	45	4
Mildura Private Hospital	220-228 Thirteenth Street	Mildura	VIC	3500	50	4
Mount Gambier Private Hospital	276-300 Wehl Street North	Mount Gambier	SA	5290	20	4
North West Private Hospital	Brickport Road	Burnie	TAS	7320	48	4
Peel Health Campus	110 Lakes Road	Mandurah	WA	6210	20	4
St Vincent's Private Hospital	Gorman Hill Road	Bathurst	NSW	2795	35	4
Wangaratta Private Hospital	134-150 Templeton Street	Wangaratta	VIC	3677	24	4
Allora District Co-op Hospital	Darling Street	Allora	QLD	4362	47	5
Ardrossan Community Hospital Inc	37 Fifth Street	Ardrossan	SA	5571	17	5
Ballan and District Soldiers Memorial Hospital	33 Cowie Street	Ballan	VIC	3342	6	5
Bega Valley Day Surgery Centre and Private Hospital	31 Parker Street	Bega	NSW	2550	12	5
Busselton Hospice	Craigh Street	Busselton	WA	6280	2	5
Chiltern and District Bush Nursing Hospital	Main Street	Chiltern	VIC	3683	14	5
Clifton Co-operative Hospital	Norman Street / PO Box 1	Clifton	QLD	4361	12	5
Cobden District Health Services	5 Victoria Street	Cobden	VIC	3266	4	5
Cooloola Community Private Hospital	78-82 Channon Street	Gympie	QLD	4570	40	5
Crows Nest and District Co-op Hospital	8 Grace Street	Crows Nest	QLD	4355	16	5

Private Hospitals With 50 Or Less Beds Potentially Eligible For The New Rural And Regional Default Benefit (Continued)

Eden Private Health Care Centre	50 Maple Street	Cooroy	QLD	4563	36	5
Euroa Hospital	Kennedy Street	Euroa	VIC	3666	20	5
Hamley Bridge Memorial Hospital	19 Albert Street	Hamley Bridge	SA	5401	25	5
Heyfield Hospital	Tyson Road	Heyfield	VIC	3858	13	5
Keith and District Hospital	PO Box 282, Hill Avenue	Keith	SA	5267	32	5
Killarney and District Memorial Hospital	Cedar Street	Killarney	QLD	4373	18	5
Mallala Community Hospital	Aerodrome Road	Mallala	SA	5502	22	5
Mater Hospital Yeppoon	Cnr Cliff & Hutton Streets	Yeppoon	QLD	4703	18	5
Mater Misericordiae Private Hospital Gladstone	Rossella Street	Gladstone	QLD	4680	30	5
Nagambie Hospital	22 Church Street	Nagambie	VIC	3608	15	5
Neerim District Soldiers Memorial Hospital	Main Road	Neerim	VIC	3831	34	5
Northern Yorke Peninsula Private Hospital	Ernest Terrace	Wallaroo	SA	5556	6	5
Pittsworth and District Hospital Friendly Society	10 Weale Street	Pittsworth	QLD	4356	39	5
Riverland Private Hospital	Maddern Street	Berri	SA	5343	21	5
Rosebery Community Hospital	Murchison Highway	Rosebery	TAS	7470	10	5
Sealake and District Hospital	33-43 McCelland Street	Sea Lake	VIC	3533	13	5
South Burnett Community Private Hospital	31 Markwell Street	Kingaroy	QLD	4610	18	5
South Coast Community Hospital Inc	Rex Hutchesson Wing, Sth Coast District Hosp., Bay Road	Victor Harbour	SA	5211	18	5
Walwa Bush Nursing Hospital Inc	Murray River Rd (Main Street)	Walwa	VIC	3709	10	5
Warley Hospital	12 Warley Avenue	Cowes	VIC	3922	13	5
Yackandandah Bush Nursing Hospital	20 Isaacs Avenue	Yackandanda	VIC	3749	17	5
Yeoval Community Hospital	Lord Street	Yeoval	NSW	2868	7	5

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-172

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE MELBOURNE AND CANBERRA OFFICES

Hansard Page: CA 214

Senator McLucas asked:

I would be interested in knowing the total cost for those employees for whom, because of the relocation, redundancy payments had to be found. There was a period, I understand, when some of the staff were based in Canberra and some of the staff were based in Melbourne. I daresay there was movement between those locations. Can you identify the costs – the travel, accommodation costs and TA, or whatever – for the period when you had staff identified in two locations above other regular travel? Is that identifiable?

Answer:

The total cost of redundancy payments for Canberra-based employees of Medibank Private was $1.4 million.

Regarding travel costs for the period when Medibank Private had both Canberra and Melbourne-based head office staff, it is not easily identifiable to distinguish between the costs attributable to head office duplication and those associated with Medibank Private staff travelling due to shareholder, regulator and other Canberra-based stakeholder interaction.

However Medibank Private's travel costs for the 2000 to 2003 years (actual or estimated) are determined as follows:

2000 FY (actual)	$2.6 m
2001 FY (actual)	$3.7 m
2002 FY (actual)	$2.9 m
2003 FY (estimate)	$2.2 m

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-175

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE MELBOURNE AND CANBERRA OFFICES

Hansard Page: CA 213

Senator McLucas asked:

For the period from September 1999 to September 2002, can you tell me what the costs for management salaries were on an annual basis? I have a range of questions here, and you might be able to provide some answers to me now. Can you tell me what the costs were for the Canberra and Melbourne headquarters? Do you have that data with you, Mr Savvides?

Answer:

Medibank Private considers the release of specific details of management salaries to prejudice the company's commercial position. Total employee expenses for the past two financial years were outlined on Page 41 of Medibank Private's 2002 Annual Report itemised under Employee Benefits Expense. The Annual Report was tabled in Federal Parliament last September.

For the 2002 financial year ending 30 June 2002, the figure was $89.512 million. For the prior year ending 30 June 2001, the figure was $87.796 million.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-176

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE MELBOURNE HEADQUARTERS

Hansard Page: CA 214

Senator McLucas asked:

What was the cost of the fit-out for the Melbourne headquarters?

Answer:

The cost of the fit-out for Medibank Private's Melbourne headquarters totalled $2.9 million.

As previously stated at June 2002 Budget Estimates, Medibank Private has in the period 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 long term savings generated through such cost items as reduced travel, accommodation and specific office accommodation costs.

Further, the equivalent rental per square metre in Canberra was $338, in comparison to current facilities in Melbourne being $281 (as stated at June 2002 Budget Estimates).

Any one-off relocation costs thus needs to be offset against the long-term savings generated.

Structurally, Medibank Private has eight divisions all centrally based within Melbourne. Notably this includes a workforce in Customer Care Line (call centre facility) and benefit claiming services.

The Medibank Private corporate workforce in Melbourne currently numbers around 520 full and part time employees, positioned within three office buildings in the CBD.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-177

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: MEDIBANK PRIVATE CANBERRA OFFICE

Hansard Page: CA 214

Senator McLucas asked:

How many were there that redundancy payments had to be found for?

Answer:

A total of 30 Canberra based Medibank Private staff accepted redundancies as a result of the Canberra office closure. This figure represented an approximate two-year period ending with the formal closure of the office in May 2002.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-173

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: CQ RESQ

Hansard Page: CA 213

Senator McLucas asked:

Have you given provider numbers to other aero rescue-type organisations?

Answer:

Medibank Private's records show that we have issued provider numbers to the Air Ambulance service operating out of Essendon Airport (Melbourne), and to the Royal Flying Doctor Service.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-174

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: CQ RESQ

Hansard Page: CA 213

Senator McLucas asked:

It just seems to be going on for quite some time without any resolution. The amount that is owed to CQ RESQ is in the vicinity of $32 000. You can understand that that is quite an enormous amount of money for a voluntary organisation to carry. Coming back to the provider number, how is the provider number different from the Health Insurance Commission provider number? Is it quite a separate thing?

Answer:

The Health Insurance Commission (HIC) issues provider numbers for a broad range of health care provider modalities. However, some health care modalities, such as speech therapy, dieticians and remedial massage, are not issued with provider numbers by the HIC.

In such instances, health funds can choose to issue provider numbers to practitioners in these modalities, provided such action does not breach the National Health Act or Fund Rules, and the practitioner in question meets appropriate standards.

The HIC has not issued a provider number to CQ RESQ.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-04, 2, 3 & 5 June 2003

Question: E03-178

OUTCOME 8: CHOICE THROUGH PRIVATE HEALTH

Topic: CQ RESQ

Hansard Page: CA 212

Senator McLucas asked:

I have been advised that CQ RESQ, which is a non-profit private company limited by guarantee, operates a community based helicopter rescue service based in Mackay in North Queensland. Medical work is the considerable part of their operations. Essentially, the issue goes to recouping funds from insurance companies and the process by which they do that. I am advised that they bill health insurers when the patient has private health insurance that covers aeromedical ambulance insurance – that is, usually, people with the highest cover.

They advise me that, in all cases where they invoice private insurers, with one exception – and that is why I am raising it – those insurers pay. You can imagine that the reason I am talking to you is that Medibank Private is the one that does not. Do you have knowledge of the correspondence between CQ RESQ and Medibank Private?
Answer:

Following receipt of two CQ RESQ invoices awaiting payment, Medibank Private's Provider HelpDesk contacted CQ RESQ and established that they did not have a Medibank Private provider number.

Medibank Private requested that CQ RESQ provide an outline of their activities to ascertain whether Medibank Private could issue a provider number.

Following this conversation, General Manager of CQ RESQ, Mr Phillip Dowler, submitted a letter to Medibank Private dated 21 May 2003, outlining the organisation's primary activities.

Upon reviewing the letter, Medibank Private advised Mr Dowler that he would need to complete an Independent Private Practice (IPP) form to better ascertain the organisation's suitability for a provider number. The form was sent to Mr Dowler in early June 2003.

Medibank Private has received an IPP form from CQ RESQ and registered them as an Ambulance transport provider. Medibank Private is writing to CQ RESQ to advise them that benefits would be payable for the purpose of obtaining immediate or urgent medical attention required for the patients well-being that is provided by a registered medical practitioner at an approved hospital or facility or other premises acceptable to Medibank Private or when medically necessary for admission to hospital.

Background:

Note: Medibank Private Fund Rule definition of Independent Private Practice
'**Independent Private Practice**', is a practice operated on an independent and self-supporting basis either as a sole partnership, or group practice but not under an agreement with, or subsidy by, another party for the provision of accommodation facilities or services. Practitioners in practice at a public Hospital or any other type or class of publicly-funded facility do not meet the guidelines applicable to 'Independent Private Practice'.

(4) Tabled by Sen Carr 5/6/03 whose estimates.

THE UNIVERSITY OF NEW SOUTH WALES

RESEARCH OFFICE

MEMORANDUM

DATE	3 June 2002
TO	Dr Xiao (Clara) He
SCHOOL/DEPT	Clinical School -SW Sydney
FROM	Jeffrey Saynor Acting Head, Grant Support Section Phone: 9385 7236 Fax: 9385 7238 Email: j.e.saynor@unsw.edu.au
SUBJECT	Continuing NHMRC Project Grant UNSW File: 992096

The NHMRC has notified us that the figures supplied earlier in the year for continuing Project Grants contained errors. The outturn has now been adjusted and revised figures supplied. They have also reminded us that they no longer send individual letters for continuing grants.

Your **revised** grant details for 2002 are as follows:

NSS Project Number:	**RMM4087**
NHMRC Reference:	**113949**
Project Title:	**Molecular Cloning and Expression of Cytokine Genes Related to Induction of Allograft Transplantation Tolerance in Rats**
Revised 2002 Award:	**$71,751.28**

If you have any enquiries regarding the administration of your grant please contact the following Research Office personnel:

Faculty of Engineering
& Faculty of Medicine - Margaret Micallef on ext 5209 (email:m.micallef@unsw.edu.au)

All other Faculties - Kate Taylor on ext 7235 (email: k.taylor@unsw.edu.au)

UNSW SYDNEY NSW 2052
AUSTRALIA
Telephone: +61 (2) 9385 7230
Facsimile: +61 (2) 9385 7238
www.ro.unsw.edu.au
ABN 57 195 873 179

THE UNIVERSITY OF NEW SOUTH WALES

CLIENT SERVICES
Financial Services Department

STATEMENT OF INCOME AND EXPENDITURE
FOR THE PERIOD
01 January 2001 to 31 December 2001

PROJECT: NHMRC
Molecular Cloning and Expression of Cytokine Genes Related to Introduction of Allograft Transplantation Tolerance in Rats
Dr XY He, Professor BM Hall

Project No. RMM4087

Cumulative $		$	Current Period $
	OPERATING REVENUE		
133,259.39	Grant received		68,230.04
1,438.50	Miscellaneous 2001 Super		1,438.50
134,697.89	**Total Operating Revenue**		69,668.54
	OPERATING EXPENDITURE		
107,157.43	Salaries & Oncosts	50,972.71	
5,858.98	Travel	3,160.77	
-	Equipment	0.00	
5,359.59	Materials	5,359.59	
	Other- Research infrastructure Charge		59,493.07
118,376.00	**Total Operating Expenses**		59,493.07
	OUTSTANDING COMMITMENTS		
-	Salaries	0.00	
-	Travel	0.00	
-	Equipment	0.00	
-	Materials	0.00	-
118,376.00	**Total Operating Expenses & Commitments**		59,493.07
16,321.89	**Operating Result**		10,175.47
-	Operating Result from previous period		6,146.42
16,321.89	**Total Result for the Period**		16,321.89
-	Add: Salary supplement from school in 2000		-
16,321.89			16,321.89

CERTIFIED CORRECT

Shirley Kueh,
Senior Accountant, Research
Financial Services Department
10-Apr-02

Where applicable, please note if any GST has been received in addition to the grant funds reported above, the GST has been forwarded to the Australian Taxation Office

UNSW SYDNEY 2052 AUSTRALIA
Telephone: +61 (2) 9385 3014
Telephone: +61 (2) 9385 2455
Telephone: +61 (2) 9385 2703
Facsimile: +61 (2) 9385 2156

Att: Senator Kim Carr

Clara He
93 Bellinger RD
Ruse 2560, NSW

27th March 2003

Mr Tony Rolfe
NHMRC
Ref:2002/000388

Dear Mr Rolfe,

RE: NHMRC Project Grant 113949 (2000-2002) Refers

There seems to be unending saga about missing funds. This time the Vice Chancellor himself is taking part. I attach the recent (post-inquiry) correspondence for your information. I will be sending a copy to Auditor General s office, although they could not find anything amiss with the research funds management practices on the part of UNSW and Professor Hall.

Sincerely

He

Clara He

Clara He
93 Bellinger RD
Ruse 2560, NSW

14th April 2003

Mr Tony Rolfe
NHMRC
Ref:2002/000388

Dear Mr Rolfe,

RE: NHMRC Project Grant 113949 Refers Further

Please find enclosed letter from Professor Hume's Office and my response. I would be grateful if you would indicate that whether or not you have received my previous documentation by fax on 27th March 2003.

Sincerely

Clara He

Clara He
93 Bellinger RD
Ruse 2560, NSW

5th May 2003

Ms Julie Hudson
Center for Research Management
NHMRC
Ref:2002/000388

Dear Ms Hudson,

RE: NHMRC Project Grant 113949 Refers Further

Thank you very much for telling me that your did not receive my fax which was sent to Mr Tony Rolfe on 14th April 2003. Mr Rolfe was the correspondent officer from NHMRC previously for this case. Please find enclosed letters from Vice Chancellor of UNSW, Professor Hume's Office and my response regarding to my grant above for your information.

Sincerely

Clara He

UNSW

16 May 2003

Dr Clara He
93 Bellinger Road
RUSE NSW 2560

PROFESSOR
ELSPETH MCLACHLAN
PRO-VICE-CHANCELLOR
(Research)

BENDER TO KEEP
CN2822828

Dear Dr He,

I am responding on behalf of the Vice-Chancellor to your letters of 14 April 2003 and 30 April 2003. I apologise for the delay. As you were advised, the Easter/Anzac Day break meant that many of the staff who could provide the financial information were not available and then I wanted to arrange the copying of the lab books etc, which you have now done. I hope that this letter will clarify the position and provide you with the information you need.

As mentioned in your letter of 14 April 2003, you as Chief Investigator A were responsible for all expenditure against NHMRC grant 113949, which was allocated project account RMM4087 at UNSW. Over the period 1 January 2002 to 21 June 2002, a number of purchases were made by Lorinda Carter at SWSAHS who had your authority to purchase from your grant. The University has never received any notice from you rescinding Ms Carter's authority. As far as UNSW understands, Ms Verma worked on the grant during this period and the laboratory records that have been copied for you should verify that this was the case. When you wrote to Professor Henry on 5 June 2002 stating that you had not authorised purchases on your card, your card was cancelled and no further charges against it were made.

During the period up to 21 June 2002, purchases against your account were for expenses incurred in Nirupama Verma's work. These total $4,946.43. Responsibility for her work was shifted to Professor Hall by the University on 21 June 2002 and all expenses since that time have not been charged to your account. Ms Verma's salary and on-costs to that date was $28,810.11. Expenses authorised by you total $667.36.

The only expenditure against your account after this time is one item of $1,360.00 (invoice number MEDIC PO5371), which I understand was authorised by you late last year.

In case you wish to reconcile these figures with information given to you earlier, some tax charges were automatically taken from the account because the wrong code had been allocated to your conference expenses. These have now been credited to the account ($745.15).

The total funds available for 2002 were $91,712.53. Allowing for the above expenditure, this means that the balance in the account is $55,928.63.

I take this opportunity to advise you that the Research Office procedures require ethical approval for animal protocols and OGTR clearance before any funds can be released from the account and it seems that there are no current approvals.

THE UNIVERSITY OF
NEW SOUTH WALES
UNSW SYDNEY NSW 2052
AUSTRALIA
Telephone: +61 (2) 9385 3375
Facsimile: +61 (2) 9385 2375
Email: e.mclachlan@unsw.edu.au
ABN 57 195 873 179

Temporary approval for animal experiments was given to you last July but this expired when no application was received by the time of the September meeting of the Animal Care and Ethics Committee It will be necessary for you to submit a new application to the Committee. The next meeting will be held on 6 June 2003 but applications must be in to the Ethics Secretariat by 23 May 2003. If you want help with this application, I suggest you speak with Dr. Minoti Apte, the SWSAHS representative, or with Associate Professor Michael Perry, Presiding Member of the ACEC on 02 9385 2556.

It will be necessary for you to submit an application for OGTR clearance via the Biosafety Committee. The next meeting will be held on 5 June 2003. Applications were to be submitted by 19 May 2003. You can contact the Secretariat about a late submission. If you want help in preparing this application, I suggest you speak with Phyllis Heggie in the Risk Management Unit (02 9382 2916), who is responsible for liaison with the OGTR. Otherwise the next meeting of the Biosafety Committee will be held on 3 September 2003 with a closing date for applications of 18 August 2003.

I hope this provides you with all the information you need. James Walsh, the Director of the Research Office will provide you with any further information or you are welcome to contact my Executive Officer, Carla Venturin, on 02 9385 2372.

Yours sincerely,

Elspeth McLachlan

Professor Elspeth M. McLachlan, D.Sc., F.A.A.,
Pro-Vice-Chancellor (Research),
The University of New South Wales

cc Professor Wyatt R Hume, Vice Chancellor
Professor Mark Wainwright, Deputy Vice-Chancellor (Research)
Professor John Ingleson, Deputy Vice-Chancellor (Education and International)
Dr Ian Southwell, CEO, SWSAHS
Professor Bruce Dowton, Dean, Faculty of Medicine
Mr James Walsh, Director, Research Office
Mrs Carol Kirby, University Solicitor

Professor W. R Hume
Vice Chancellor
University of New South Wales

22 May 2003

Clara He
93 Bellinger RD
Ruse 2560

Dear Professor Hume,

RE: NH&MRC grant 113949, RMM4087 refers

Thank you very much for arranging the notarised copy of Ms Nirupama Verma's laboratory books. I have reviewed these books and attributed generous (usually double the actual) amounts of time needed for each recorded activity. Despite this I find that the total amount of time expended on work encompassed by my NH&MRC grant totaled 8.5 weeks (say 9 weeks for simplicity) out of a possible 26 weeks. Thus the inappropriate salary impost on the grant totals $18,837.38.

I also note from Professor McLachlan s letter dated 16 May 2003 that the actual salary impost from 1 January 2002 to 20 June 2002 was $28,810.11 which is less than my estimate of $ 31,550.40 and so leaves another $2,740.29 of expenditure to be accounted for.

It is difficult to reconcile Professor McLachlan's letter with the amounts I have relating to NH&MRC 113949, University Account RMM4087. Professor McLachlan states that funds available for 2002 were $91,712.53. However, as I wrote on 26th March 2003 the original advice from NH&MRC stated that the grant totaled $69,985.31. This was revised to 71,751.28 in June 2002. Addition of funds carried forward from 2000 ($6,146.42) and 2001($10,175.47) made a total of $88,073.17. Addition of the amount by which you had stated that the account was overdrawn $8,918.60, results in a total of $96,991.77. Neither total approximates that of Professor McLachlan ($91,712.53).

Professor McLachlan states that Ms Verma's salary (1.1.2002-20.6.02) with on cost was $28,810.11 and your earlier letter indicates that her salary for the period 21.6.02-10.4.03 was $50,679.71 giving a total of $79,489.82. (My estimate had been $82,230.31). Leaving unaccounted for moneys totaling $17,501.95. Ms Betsy Marks had forwarded by e-mail imposts totaling $7,006.99 of which $667.36 was authorised by myself and $841.41 post dates June 21, 2002. This includes the returned tax amounts of $709.81. The residual of unauthorised expenditure to June 2002 is thus $5,498.22 from $7006.99, not $4.946.43 as stated by Professor McLachlan.

The pipettes ordered by myself cost $1360.00 so that the total amount of unauthorised for and unaccounted for expenditure from RMM4087 is $14,764.78 (unauthorised $5,498.22, unexplained $9,266.56).

I note from Professor McLachlan's letter that the account balance now stands at $55,928.63 suggesting that a total of $5,248.92 of the unauthorised expenditure has been re-imbursed, leaving only $9,515.86 to be accounted for. I would appreciate a detailed account of these amounts to determine which amounts relate to grant number 113949.

With regard to Professor McLachlan's statements that I had delegated authority to Ms Lorinda Carter to purchase from account RMM4087. I have never delegated authority to purchase without my specific request to Ms Carter. It is not possible to rescind that which I have never given. The only items that I requested Ms Carter to purchase were pipettes (MEDIC PO5371) totaling $1360.00 in 2002. Neither did I delegate authority to purchase to Ms Verma.

With regard to Professor McLachlan's other comments I shall apply to Animal Ethics but as the gene transfection work for the project is already complete I do not now need OGTR clearance.

I would be grateful for the itemised accounts for the remaining $ 9,515.86 at your earliest convenience.

Sincerely

Clara He

NHMRC
National Health & Medical Research Council

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

Dear Mr Humphrey

Additional Estimates Hearing of 5 June 2003: Outcome 9

On 5 June 2003 I appeared before the Senate Community Affairs Legislation Committee to answer questions in relation to Outcome 9: Health Investment.

I would like to clarify statements made by me at this time in relation to NHMRC Project grants 209656 and 113949.

There were two grants under discussion in the Hearing.

In relation to grant 209656, the position of the Department's Audit and Fraud Control Branch (AFCB) is that it requires evidence of scientific fraud before considering whether they refer the matter to the Australian Federal Police. Once the AFCB has access to the final report of the External Independent Inquiry into this matter, it will be able to determine if it needs to be referred.

In relation to grant 113949, while I advised the Committee that AFCB's investigation of allegations about misappropriation of Commonwealth money "found nothing", in fact the AFCB report found "it would not be possible to substantiate a case that Professor Hall misused funds for grant 113949 in a manner which implies an offence under the *Criminal Code".*

During the Hearing there was some lack of clarity in my answers, which were mainly in respect of 113949, rather than 209656, which was the grant about which Senator Carr was asking questions.

The second recommendation of the AFCB report is about giving NHMRC grant approval and acquittal processes a high priority on AFCBs financial loss and risk assessment program and not about how consumables and staffing costs are allocated. These latter issues were issues which the NHMRC undertook to provide advice to institutions about, in response to AFCB recommendations.

Suzanne Northcott
Executive Director
Centre for Research Management
25 June 2003

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 June 2003

Question: E03-269

OUTCOME 9: HEALTH INVESTMENT

Topic: INTERDEPARTMENTAL REVIEW OF CUSTOMS REGULATIONS BAN ON THE EXPORT OF HUMAN EMBRYOS

Senator Harradine asked:

In February I asked the following questions about at inter-departmental review to be undertaken of the Customs regulations ban on the export of human embryos. Little detail was then available because the committee had not been formed. If the committee has now been formed, would you please advise me:

(a) What are the terms of reference of the committee?
(b) What are the names of the officers on the committee and their departmental affiliations?
(c) What is the plan for how the review will be undertaken?
(d) What is the aim of the review ie. will it be focused on achieving an ethical outcome, advancing the research interests of scientists in this area or a commercial outcome?
(e) Will the results of the review be made public? If not, why not?
(f) Has the Prime Minister received representations from individuals or organisations lobbying against the ban on the export of human embryos? If so, who are the individuals/organisations and would you please provide copies of the correspondence?
(g) Will the review be considered by the Prime Minister? If not, why not? Who will make the final decision?

Answer:

(a) While the terms of reference are yet to be finalised, the Interdepartmental Committee (IDC) met for the first time on 25 July 2003. However, the following statements from the debate in the Senate on the Prohibition of Human Cloning Bill are relevant:

Senator Patterson (Hansard ref): Tuesday, 12 November 2002 pp 6141 – 6162.
Senator Ellison (Hansard ref): Thursday, 14 November 2002 pp 6336 – 6342.

(b) The Interdepartmental Committee was convened by the National Health and Medical Research Council (NHMRC) and has representation from the following Departments and Commonwealth organisations:

- Department of Health and Ageing (including the Therapeutic Goods Administration);
- Department of Prime Minister and Cabinet;
- Australian Customs Service;
- Attorney-General's Department;
- Department of Industry, Tourism and Resources (Biotechnology Australia) and
- Department of Foreign Affairs and Trade.

Representation on the IDC is at Director and Assistant Secretary level.

(c) The IDC will be seeking advice from relevant Ministers in relation to the focus and scope of the review.

(d) While the terms of reference and focus and scope of the review are yet to be finalised, it is anticipated that the IDC will review the current arrangements for the exportation of human embryos and provide advice to relevant Ministers relating to long-term arrangements for the exportation of human embryos. Advice will take into account the broad range of interests and priorities relating to this issue, so that Government can make a balanced decision that takes into account the needs of affected individuals and organisations. It is also anticipated that the IDC will review the ban on the importation of viable materials from human embryo clones, 12 months following its implementation.

(e) The relevant ministers will determine whether the outcome of the review will be made public.

(f) & (g) These questions should be answered by the Department of Prime Minister and Cabinet.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-071

OUTCOME 9: HEALTH INVESTMENT

Topic: HREC - RESEARCH INVOLVING HUMAN EMBRYOS ACT

Written Question on Notice

Senator Harradine asked:

(a) In your response to question E03-026 you noted that the NHMRC had produced a document to assist HREC's to understand their role under the Research Involving Human Embryos Act. Please provide a copy of this document.
(b) Are HREC's required to notify their existence to the AHEC? If not, what steps does the AHEC take to identify or encourage HREC's to notify them of their existence?
(c) What is the obligation on HREC's to notify their existence to the AHEC?
(d) What is your assessment of the number of HREC's that remain not notified to the AHEC?

Answer:

(a) The document is 'Information for Human Research Ethics Committees considering proposals for the use of excess ART embryos'. It is available on the NHMRC website at www.nhmrc.gov.au/clonebil/pdf/number3.pdf.

(b) An HREC is required to notify its existence to the NHMRC:
- for its institution to be eligible for NHMRC funding;
- where the HREC is the approving HREC for a clinical trial conducted under the Therapeutic Goods Act 1989;
- where the HREC is required to apply the Guidelines under Section 95 of the Privacy Act 1988;
- where the HREC is required to apply the Guidelines approved under Section 95A of the Privacy Act 1988;
- where the HREC is the approving HREC for research involving human embryos under Section 22 of the Research Involving Human Embryos Act 2002.

(c) An HREC is obliged to notify its existence to the NHMRC if:
- its institution wishes to be eligible for NHMRC funding;
- the HREC wishes to approve a clinical trial conducted under the Therapeutic Goods Act 1989;
- the HREC wishes to apply the Guidelines under Section 95 of the Privacy Act 1988;
- the HREC wishes to apply the Guidelines approved under Section 95A of the Privacy Act 1988;
- the HREC wishes to support an application for a licence under Section 22 of the Research Involving Human Embryos Act 2002.

(d) It is not possible to know how many HRECs are in existence and have not notified the fact to the NHMRC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-072

OUTCOME 9: HEALTH INVESTMENT

Topic: HREC - CONFIDENTIALITY

Written Question on Notice

Senator Harradine asked:

There is a general assumption that the workings and decisions of HRECs should remain confidential.

(a) Please explain why it has been decided that HREC work should not be open to the public.

(b) Doesn't this go against the trend towards openness and accountability, where for instance freedom of information legislation has an assumption that documents are available to the public unless there is a particular reason for exemption?

(c) Would it not strengthen the system of HRECs to have them more transparent and accountable, ensuring that they are in fact properly functioning bodies?

(d) Given that HRECs have an important impact on the administration of government policy and have been cited by the Health Minister as part of a strict system of regulation, should not their deliberations and decisions be open to the public?

Answer:

(a) Institutions which have established HRECs are responsible for deciding whether, and if so to what extent, HREC work will be made public.

The NHMRC has however advised HRECs to consider the information provided by researchers as confidential in respect of:

- it not being used for a purpose other than the purpose for which is was provided;
- it not being disclosed without the consent of the researcher as it will contain personal (ie. identifying) information.

(b) Institutions which have HRECs must decide whether, and if so to what extent, HREC work will be made public. Many institutions will be subject to Freedom of Information (FOI) legislation and will assess requests for information about the work of the HREC in accordance with the legislation. Many institutions which have HRECs are not subject to FOI legislation and are not, for that reason, obliged to make information available to the public.

(c) The goals of transparency and accountability need to be balanced with the obligations that institutions and HRECs owe to researchers, which, on present advice, include obligations of confidentiality. The NHMRC provides guidelines for the establishment and operation of HRECs and in the review of the ethical acceptability of research. The NHMRC assesses the HRECs' compliance with these guidelines on an annual basis for the purpose of establishing that they are functioning properly.

(d) AHEC, in its policy 'Public access to information about Human Research Ethics Committees held by the Australian Health Ethics Committee' encourages HRECs and their institutions to have transparent methods of accountability and to allow public scrutiny of research as recommended in the *Report of the review of the role and functioning of Institutional Ethics Committees 1996*. Responsibility for the disclosure of information regarding the deliberations and decisions of an HREC however rests with the institution.

These documents are available at www.nhmrc.gov.au/issues/pubacc.htm and www.nhmrc.gov.au/publications/synopses/e34syn.htm respectively.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2,3 & 5 June 2003

Question: E03-073

OUTCOME 9: HEALTH INVESTMENT

Topic: HREC COMPLIANCE WITH NHMRC GUIDELINES

Written Question on Notice

Senator Harradine asked:

(a) In your response to question E03-026(b) (Additional Estimates Feb 2003) you noted that the AHEC prepares an annual report to the NHMRC's Research Committee regarding HREC compliance with NHMRC guidelines and a report to the Federal Privacy Commissioner. Please provide me with copies of the reports for the last five years.
(b) Does the NHMRC recognise that competitive funding plays a vital role in the research of regional universities like the University of Tasmania?
(c) The Education Minister Brendan Nelson has acknowledged that regional universities "play a role in the economic and social life of their communities which goes far beyond their traditional education activities". Does the NHMRC recognise the important role of research to regional universities and their communities?
(d) Given the important impact of research on regional universities and communities, what is the NHMRC doing to assist regional universities in undertaking research?

Answer:

(a) Attached are copies of reports covering the three year period 1 July 1999 to 30 June 2002, from AHEC to the NHMRC's Research Committee, regarding HREC compliance with NHMRC guidelines. With regards to the HREC compliance report for 2001-2002, this is labelled interim, as at the time of the report, in December 2002, 6 Human Research Ethics Committees (HRECs) were non-compliant. The issues of non-compliance were resolved to the satisfaction of the CEO of the NHMRC, and Chairs of the Australian Health Ethics Committee and Research Committee, prior to the allocation of funding by the NHMRC in January 2003. A final written report however was not prepared.

Also attached are reports covering the three year period 1 July 1999 to 30 June 2002, from AHEC to the Federal Privacy Commissioner. AHEC has only reported to the Federal Privacy Commissioner for the last three years, therefore there are no reports covering the period prior to 1 July 1999.

(b) The National Health and Medical Research Council (NHMRC) is the Commonwealth Government's main health and medical research funding body.

Regional universities play an important role in Australian health and medical research. Competitive funding is vital in this regard. For instance, in 2002, the NHMRC provided approximately $1.8 million in funding to the University of Tasmania. In 2003, it will receive approximately $1.7 million. The proportion of all NHMRC funding received by Tasmania has remained relatively constant since 1995.

It is important to recognise the role played by the non-university sector involved in health, such as medical research institutes and hospitals. These institutions provide a research base that can be, and is utilised by, universities in carrying out their prime functions, including the teaching of undergraduates and the training of research students at all levels. Approximately 30% of NHMRC funding is administered by non-university institutions, such as medical research institutes and hospitals.

(c) The NHMRC recognises the important role of research to regional universities and their communities. The NHMRC's focus, however, must remain within the bounds of the National Health and Medical Research Council Act 1992, which is to: "inquire into, issue guidelines on, and advise the community on, matters relating to, the improvement of health; and the prevention, diagnosis and treatment of disease; and the provision of health care; and public health research and medical research; and ethical issues relating to health" and "to advise, and make recommendations … on expenditure on public health research and training; and on medical research and training." The NHMRC provides funding for health and medical research on a competitive basis. There is a rigorous peer-review process to ensure that the best research proposals, with the highest degree of scientific merit, are funded.

(d) The NHMRC funds health and medical research across a wide range of disciplines on the basis of excellence. As a general rule, the NHMRC does not direct researchers to undertake research in a particular area, but rather relies on the researchers themselves to determine the topics for investigation. Those research proposals that have the highest degree of scientific merit, as determined by a rigorous system of peer review, receive funding. The NHMRC's rigorous peer-review processes are designed to ensure that only the best research proposals are funded.

The recent changes to the NHMRC's funding schemes are aimed in part at fostering collaboration between researchers. Therefore, there are likely to be a number of opportunities for researchers at regional institutions to collaborate with those from other institutions to increase the amount of research conducted in regional areas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-031

OUTCOME 9: HEALTH INVESTMENT

Topic: EXPERT COMMITTEE ON HUMAN EMBRYO AND STEM CELL RESEARCH

Written Question on Notice

Senator Collins and Senator Harradine asked:

(a) With reference to question E03-001(b), are the names and background details of each of the members of the Expert Committee on Human Embryo and Stem Research now available? If so, please provide.

(b) Why was it considered necessary to establish this new committee as there was only a short time leading up to the establishment of the licencing committee? Why could not AHEC have filled this role?

(c) What is the status of the expert committee now that the licencing committee has been established? If the expert committee is to continue, what is the relationship between the two? How much funding has the department provided to the expert committee and please provide details of how it was spent?

(d) Who has the expert committee advised since its establishment? Please provide copies of the advice.

Answer:

(a) The expert committee referred to in question E03-001(b) has not been established. While the Research Committee (RC) of the National Health and Medical Research Council did appoint Professor Lyn Beazley of the School of Biology, University of Western Australia, as Chair, the RC and the Council subsequently revised the terms of reference, following passage of the Research Involving Human Embryos Act 2002. RC will reconsider membership of the new committee, now called the Expert Committee on Human Stem Cell Research (ECHSCR), when it is reconstituted for the 2003-2006 triennium.

(b) At its meeting on 9 August 2002 the National Health and Medical Research Council (NHMRC) identified that the expert committee was needed in order to provide authoritative advice to the Council, researchers, ethics committees and other interested parties on technical aspects of human embryos and stem cell research and related issues prior to the establishment of the Licensing Committee.
The NHMRC resolved that AHEC does not have the scientific and technical expertise to provide advice on human embryos and stem cell research.

(c) The NHMRC still considers the expert committee necessary. The Licensing Committee considers applications for licences to use excess Assisted Reproductive Technology embryos. The expert committee will provide advice through the Research Committee to Council and its Principal Committees, governments and the scientific and general community on scientific, medical and technical issues about human stem cell research and related matters.

No funds have been provided to or spent by the expert committee at this stage.

(d) The expert committee has not convened and no advice has been provided.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-075

OUTCOME 9: HEALTH INVESTMENT

Topic: ETHICAL GUIDELINES ON THE USE OF REPRODUCTIVE TECHNOLOGY IN CLINICAL PRACTICE AND RESEARCH

Written Question on Notice

Senator Harradine asked:

Would you please advise me why the NHMRC draft *Ethical Guidelines on the use of Reproductive Technology in Clinical Practice and Research* does not include:

(a) A requirement for the donor couples to be told of the uses or end-uses of human embryos or of human embryonic stem cells;

(b) A prohibition of the reproductive uses of a human embryonic stem cell, such as in the Nagy experiment with mice in which a mouse was wholly derived from mouse stem cells cultured on a background tetraploid mouse embryos;

(c) A definition of an embryo, so cloning human embryos has not been prohibited, provided that a scientist does not call the product of somatic cell nuclear transfer an embryo or does not call the product of a Nagy-type experiment an embryo?

Answer:

It is important to note that revision of the draft guidelines is not completed, and that the final version of the guidelines may provide different information.

(a) The guidelines emphasise the need for informed consent for ethical clinical practice and research at all times. In the current draft, Chapter 16 “Research and other activities involving embryos”, clause 16.2 states:
“16.2 Research or other activities on an embryo that has been donated for such purposes must not be approved by an HREC unless all of the following conditions have been met:…”

These conditions include clause 16.2.7 as follows:
"16.2.7 In obtaining consent, researchers ensure that embryo donors are given all relevant information to comply with the National Statement, including a full explanation of:

- the proposed research or other activities (including the proposed method and its scientific aims);
- why it would represent a significant advance in knowledge or improvement in technologies for treatment;
- what will happen to each embryo, including, where applicable, that embryonic stem cells may be derived from them and that any cells or cell lines so derived may be kept for some years;
- where applicable, that the results of research may have commercial potential; the embryo donors should understand and agree that they will not receive financial or any other benefits from any such future commercial development; and
- the arrangements for monitoring and reporting of the research or other activity by the HREC."

It should be noted that these draft guidelines may change as a result of public consultation and further consideration by CREGART and AHEC.

(b) In Chapter 3, "Unacceptable Practices", the unacceptable practices are directly related to the prohibitions provided in the *Prohibition on Human Cloning Act 2002* and the *Research Involving Human Embryos Act 2002*. Clauses 3.3 and 3.4 state that it is an unacceptable practice to:

"3.3 Creat(e) a human embryo for a purpose other than by fertilisation of a human egg by a human sperm."; and

"3.4 Creat(e) a human embryo for a purpose other than achieving a pregnancy in a woman."

It should be noted that these draft guidelines may change as a result of public consultation and further consideration by CREGART and AHEC.

(c) Definitions of the human embryo for inclusion in the draft guidelines are still under revision. Current definitions are provided in *Key Definitions* as follows:

"Key Definitions

- Chimeric embryo:
  A human embryo into which a cell, or any component part of a cell, of an animal has been introduced. *See also* Hybrid embryo.

- Donated embryo:
  An embryo given by either the gamete providers or the persons for whom the embryo was created to other persons for use in a reproductive procedure. The term is also used when the gamete providers for an embryo agree for their embryo to be used in research or other activities that will not involve implantation of the embryo. S*ee also* Embryo donor.

- Embryo donor:
  A person who has responsibility for decisions about the use of an embryo and who donates the embryo to another person or persons for treatment, or for research or other activities.

- Embryonic stem cell:
  An undifferentiated cell obtained from the inner cell mass of a blastocycst that is a precursor to many different cell types.

- Embryonic stem cell line:
  A cell culture derived from an embryonic stem cell that can be propagated indefinitely.

- Human embryo:
  A live embryo that has a human genome or an altered human genome and has been developing for less than eight weeks since the appearance of two pronuclei or the initiation of its development by any other means (not including any period when its development was suspended for any reason).

- Human embryo clone:
  A human embryo that is a genetic copy of another living or dead human but does not include a human embryo created by the fertilisation of a human egg by a human sperm.

- Hybrid embryo:
  (a) an embryo created by the fertilisation of a human egg by animal sperm; or
  (b) an embryo created by the fertilisation of an animal egg by human sperm; or
  (c) a human egg into which the nucleus of an animal cell has been introduced; or
  (d) an animal egg into which the nucleus of a human cell has been introduced.

See also Chimeric embryo."

It should be noted that these draft guidelines may change as a result of public consultation and further consideration by CREGART and AHEC.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2,3 & 5 June 2003

Question: E03-076

OUTCOME 9: HEALTH INVESTMENT

Topic: SA VARIANCE TO COMMONWEALTH LEGISLATION ON RESEARCH INVOLVING HUMAN EMBRYOS ACT

Written Question on Notice

Senator Harradine asked:

The South Australian Parliament has recently passed legislation similar to the Research Involving Human Embryos Act, but I understand that they also passed an amendment which is at variance from the Commonwealth legislation.

(a) What is the effect of this amendment and how will it impact on the Australian regulatory system?
(b) What were the arguments used to support the amendment?
(c) What legal advice have you offered to the Minister on this amendment?
(d) Does this amendment threaten the COAG approach for uniform legislation?
(e) What options does the Government have to respond to this amendment?
(f) What options does COAG have to respond to this amendment?

Answer:

(a) The effect of the amendment is that, for the South Australian legislation, the 5 April 2002 restriction would not be lifted until 5 April 2005 regardless of any interim decisions made by the Council of Australian Governments (COAG). This may potentially impact on South Australian researchers who are covered only by the South Australian legislation.

(b) The Member that moved the amendment, the Hon Mr John Rau, Member for Enfield, argued that any decision regarding early removal of the 5 April 2002 restriction should be made by elected members of Parliament rather than by COAG.

(c) The Minister for Ageing was provided with internal legal advice indicating that decisions relating to declaration of State laws as corresponding were at his discretion. The Minister was further advised that if he declared the South Australian Act to be a corresponding State law and COAG subsequently decided to lift the 5 April 2002 restriction before 5 April 2005, a potential inconsistency may occur between the Commonwealth and South Australian Acts.

(d) & (e)
On 3 October 2003, the Minister declared the South Australian legislation to be a corresponding State law. The potential impact on national consistency and the Minister's options for response are outlined in the response to part (c) above.

(f) The NHMRC is not able to comment on the deliberations of COAG.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-077

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC LICENSING COMMITTEE - MEMBERS

Written Question on Notice

Senator Harradine asked:

(a) Please provide names and backgrounds of all nominations to the Licensing Committee and the nominating bodies for each person.
(b) Which nominees did each state or territory or the Commonwealth favour?
(c) Please provide reasons for each decision to appoint each of the members.
(d) How much funding is the NHMRC providing to the Licensing Committee?
(e) Re Question E03-034, will the decisions of the licensing committee in response to each application be publicly available?

Answer:

(a) The Minister sought nominations from bodies prescribed in the *Research Involving Human Embryos Regulations 2003* and from the responsible Minister in each State and Territory. The names were provided to the Minister and the NHMRC cannot provide this information.

(b) Before appointing the NHMRC Licensing Committee, the Minister for Ageing, the Hon Kevin Andrews consulted with responsible ministers in each State and Territory in accordance with the requirements of the *Research Involving Human Embryos Act 2002*. The Act also states that the Minister cannot appoint the Chairperson or member with expertise in the regulation of assisted reproductive technology unless a majority of States and Territories agree with that appointment.

(c) Members were appointed by the Minister in accordance with the requirements of the *Research Involving Human Embryos Act 2002*. The Act requires that the Minister appoint:

- a member of the Australian Health Ethics Committee;
- a person with expertise in research ethics;
- a person with expertise in a relevant area of research;
- a person with expertise in assisted reproductive technology;
- a person with expertise in a relevant area of law;
- a person with expertise in consumer health issues relating to disability and disease;

- a person with expertise in consumer issues relating to assisted reproductive technology;
- a person with expertise in the regulation of assisted reproductive technology; and
- a person with expertise in embryology.

Before appointing the Committee, the Minister:

- sought nominations from States and Territories and from bodies prescribed by the *Research Involving Human Embryos Regulations 2003*;
- consulted and had regard to the views expressed by, the States and Territories on the proposed appointments; and
- sought majority agreement of the States and Territories before appointing the Chairperson and the member with expertise in the regulation of assisted reproductive technology.

(d) Funding for implementation of the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002* is as outlined in the Portfolio Budget Statement 2003-2004, page 234.

(e) Details relating to each licence issued by the Licensing Committee will be made available through a public database.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-078

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC LICENSING COMMITTEE - OTHER RELATED COMMITTEES

Written Question on Notice

Senator Harradine asked:

I note recent establishment of at least three related committees – the Licensing Committee, the Committee to revise the ethical guidelines on assisted reproductive technology and the Expert Committee on Human Embryo and Stem Cell Research. How will they coordinate their activities, both with each other and with AHEC?

Answer:

The three committees provide distinct but interrelated functions.

The **Licensing Committee** is a new Principal Committee of the National Health and Medical Research Council (NHMRC). The other three are the Research Committee, the Australian Health Ethics Committee and the Health Advisory Committee. The Licensing Committee considers applications for licences to use excess assisted reproductive technology embryos in accordance with the *Research Involving Human Embryos Act 2002*. The Licensing Committee will report biannually to Parliament and make available, through a public database, relevant details of each licence issued.

The **Committee to Revise the Ethical Guidelines on Assisted Reproductive Technology** (CREGART) is a sub-committee of the Australian Health Ethics Committee (AHEC) of the NHMRC. The primary task of CREGART is to revise the *Ethical guidelines on assisted reproductive technology* (1996).

The Expert Committee on Human Embryo and Stem Cell Research was not established. However, the **Expert Committee on Human Stem Cell Research** (ECHSCR) will be established as a sub-committee of the Research Committee (RC) of the NHMRC when the newly appointed RC meets for the new triennium.

ECHSCR will provide advice through RC to Council and its Principal Committees, governments and the scientific and general community on scientific, medical and technical issues about human stem cell research and related matters. ECHSCR will also provide advice to Human Research Ethics Committees on specific research applications proposing to use human stem cells and monitor developments on human stem cell research in Australia and overseas.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-082
(revised)

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC LICENSING COMMITTEE - MEMBERS AND MINUTES

Written Question on Notice

Senator Harradine asked:

(a) When was the first meeting of the Licensing Committee? Please provide copies of the minutes.
(b) Do members of the Licensing Committee have to step down from the committee to avoid a conflict of interest while the Committee is considering applications from organisations with which a member may have some connection?
(c) Is it the NHMRC's position that members of the Licensing Committee are allowed to have conflict of interest and still consider an application as long as they do not stand to benefit financially from the outcome?

Answer:

(a) The first meeting of the Licensing Committee was held on 4 June 2003. The minutes of the meeting have now been finalised and approved for release by the Chair of the Licensing Committee. A copy of the minutes is provided at Attachment 1.

(b) & c) Section 16(3)(c) of the *Research Involving Human Embryos Act 2002* prevents the appointment to the Licensing Committee of any individual with a direct or indirect pecuniary interest in a body that undertakes the use of excess ART embryos.

If a member of the National Health and Medical Research Council or a Principal Committee (such as the Licensing Committee) has any conflict of interest, he or she must not be present when the Committee considers the matter, or take part in any decision of the Committee in relation to the matter, unless the Chairperson of the Committee otherwise determines. If the Chairperson of the Licensing Committee has declared an interest, he or she must not be present when the Committee considers the matter, or take part in any decision of the Committee in relation to the matter, unless the Chairperson of the National Health and Medical Research Council (NHMRC) otherwise determines.

Section 28 of the *NHMRC Act 1992* requires that the Minister terminate the appointment of a member of the Council or a Principal Committee for failure to comply, without reasonable excuse, with the disclosure of interest requirements prescribed at Section 29 of that Act.

NHMRC LICENSING COMMITTEE

Minutes of the Meeting of 4 June 2003

ATTENDANCE

Members:

Professor Jock Findlay (Chairperson)
Dr Megan Best
Dr Kerry Breen
Professor Don Chalmers
Dr Peter Illingworth
Dr Graham Kay
Dr Christopher Newell
Dr Julia Nicholls
Ms Helen Szoke

Secretariat

Dr Clive Morris
Mr Tony Rolfe
Ms Leanne K Mundy

As required for particular sessions:

Professor Alan Pettigrew (CEO, NHMRC)
Mr Nicholas Duell
Mr Phillip Hoskin
Dr Alison Mackerras
Mrs Rhonda Stilling
Mr Martin Boling

Legal Services Branch,
Department of Health and Ageing

Ms Belinda Carman
Mr Ross Andrews

Item 1: .....WELCOME AND INTRODUCTION

All meeting participants introduced themselves and provided relevant background about their experience.

The Committee noted that the NHMRC must cause an independent review of the operation of the Acts to be undertaken as soon as possible after the second anniversary of Royal Assent. This report must contain recommendations about any amendments that should be made to the Act.

The role of the NHMRC's Expert Committee on Human Stem Cell Research (ECHSCR) was noted.

Decision:

Committee to consider the process for collecting information required to inform the review.

Item 2: ADMINISTRATIVE ARRANGEMENTS

Member information, including Council committee procedures, was noted.

The Committee will consider whether there is a need to establish an executive

Members were advised that they should not respond directly to external queries, but rather should direct these to the Licensing Committee Secretariat for response. At times the Secretariat will need to contact Members for advice, but the response will always come from the NHMRC rather than an individual Committee Member.

Members noted that all media queries must in the first instance be directed to the NHMRC's Communications Unit and should rely on the Chair as the point of contact for the media.

Decision:

Committee will consider whether there is a need to establish an executive.

Whenever possible decisions will be made by consensus.

All queries received by Members of the Committee will be forwarded to the NHMRC Licensing Committee Secretariat or Communications Unit for consideration and action.

Item 3: CONFIDENTIALITY

The importance of confidentiality was noted. Members were reminded that all committee discussions must remain confidential, and that meeting papers should be disposed of as confidential material.

Members were assured that the Department's firewall is very secure and there need be no concerns regarding any breach of confidentiality in respect of material conveyed electronically.

Responsibility in relation to 'confidential commercial information' was also noted.

The Committee will ensure that that confidentiality is maintained.

Item 4: LEGISLATIVE FRAMEWORK

Item 4.1: Overview

Members noted the legislative framework within which they are required to work. Queries pertaining to both the *Research Involving Human Embryos Act 2002* and the *Prohibition of Human Cloning Act 2002* were answered by the Department of Health and Ageing's legal representatives.

The Committee was mindful of the social context in which it works.

Members agreed that it is important to ensure that the work of the Committee will stand up to public scrutiny, and that therefore it needs to develop a set of principles that will guide its decision making.

Decision:

Members agreed to develop a set of principles to guide its decision making process.

Item 4.2: Interaction between Commonwealth and State/Territory legislation

The requirement for nationally consistent legislation was noted, as well as the related development of an Inter-Government Agreement (IGA) signed by the Prime Minister and Premiers and lower level bilateral agreements to be covering issues such as communications, the roles of the Commonwealth and the States, Inspectors, cost sharing etc.

The State and Territory legislation is currently being developed to complement Commonwealth legislation. The status is as follows:

- Legislation on cloning and research involving human embryos has been passed in Queensland;

- Legislation on cloning and research involving human embryos has been passed in Victoria but is yet to receive Royal Assent;

- Legislation on cloning and research involving human embryos was passed in South Australian House of Assembly with minor amendments on 29 April 2003. The amended Bills were passed in the South Australian Legislative Council on 5 June 2003;

- Legislation on cloning and research involving human embryos has been passed in the New South Wales Legislative Assembly on 19 June 2003. The legislation will be tabled in the Legislative Council shortly.

- Legislation on cloning and research involving human embryos has been tabled for debate in the Western Australian Parliament.

- Legislation is being drafted in the Australian Capital Territory and the Northern Territory;

- Drafting of the legislation has not yet commenced in Tasmania.

Members were advised that the Commonwealth law will apply in all States and Territories, within the limits of the Commonwealth's constitutional powers. States and Territories, through COAG, agreed to introduce concurrent legislation which will reflect the terms of the Commonwealth legislation. Further, where there is inconsistent State legislation in place, the Commonwealth legislation would override State legislation, but only to the extent that is necessary to remove the inconsistency.

The Committee will be kept informed of progress in the development of nationally consistent legislation.

Item 4.3: Prohibited Practices

Members noted prohibited practices and that the Committee will appoint Inspectors who will monitor activities to ensure compliance with legislation. It was agreed that the Committee has a responsibility to make sure people are aware of this legislative requirement and the penalties that are in place should there be a breach of the legislation.

Decision:

Secretariat to ensure that organisations are well informed about prohibited practices.

Item 4.4: Definitions

Members considered papers provided.

a) Embryo

The definition of embryo contained in the legislation should always apply. Stakeholders should be made aware of this definition.

b) Succumb

The Committee agreed to develop a definition of succumb.

c) Proper Consent

The paper on the review of the current NHMRC Ethical Guidelines on ART was noted. This review is still in progress and is some 6-12 months away from conclusion. It was agreed that the Committee should have a role in working co-operatively with AHEC in that review. In the interim, applications must be considered in the light of the existing NHMRC *Ethical Guidelines on Assisted Reproductive Technology 1996* (noting that the definition of 'proper consent' contained in the legislation is linked to these guidelines).

To facilitate this process, the Committee needs to establish internal guidelines around what would be required for it to be 'satisfied' that appropriate protocols are in place to enable proper consent to be obtained before an excess ART embryo is used (as required by section 21 (3) (a) (i) of the *Research Involving Human Embryos Act.* This could then be used to inform HRECs.

A draft document, designed to inform the Committee's operations and provide additional guidance to HRECs, bridging the gap between the *Ethical guidelines on ART 1996* and the revised document, will be prepared.

Secretariat will confirm with AHEC secretariat that HREC used by applicants is in compliance with all requirements.

Decision:

Stakeholders to be made aware of the definition of 'embryo', as defined by the legislation.

Committee to develop a definition of 'succumb'.

Applications will be considered in the context of the *Ethical Guidelines on Assisted Reproductive Technology* 1996.

Prepare a document on proper consent for inclusion in advice to HRECs.

4.5 Likelihood of Significant Advance

In the area of training and quality assurance it may be useful to consult SIRT to obtain additional advice and background information. A guest speaker could be asked to address the next meeting.

In the case of research, the Committee agreed that to obtain additional expert advice on a case-by-case basis. To facilitate this, a list of both national and international experts will be established. The use of international experts will help to overcome potential lack of available experts due to conflict of interest.

The qualifications and experience of the Principal Supervisor is pertinent to this question. The Principal Supervisor will be required to provide a full CV, including a list of relevant publications to the Secretariat.

Further consideration needs to be given to how much information is required about the skills and experience of other staff involved in the proposed work. This is particularly important where activities are happening at different sites.

Decision:

A panel of national and international experts to be established. Secretariat to explore whether such experts can be paid for advice provided.

Dr Breen to provide a paper on relevant requirements of the *National Statement on Ethical Conduct in Research Involving Humans.*

Application form to be amended to require a full CV for the Principal Supervisor. Further consideration to be given to the requirements for other staff.

Item 4.6: Number of Embryos

Members noted that the legislation required that the Committee have regard to restricting the number of excess ART embryos that are likely to be necessary to achieve the goals of the activity proposed.

The Committee again considered that they may at times need to seek additional expert advice - refer 4.5. It may also be necessary to include statistical expertise and formation of a dedicated statistical reference group may be useful.

Decision:

Expert advice to be obtained – refer Item 4.5

Ongoing consideration for the need of a dedicated statistical reference group.

Item 4.7: Damage or Destroy Embryo

Applicants to be required to put as much information as possible into applications to aid the Committee's decision making. Clear guidance needs to be given as to what is meant by "succumb" in contrast to "damage or destroy".

Decision:

Secretariat to ensure that applicants are asked to provide detailed information about the proposed activity.

Non destructive use of embryos created after 5 April 2003 to be addressed at the next meeting of the Committee.

Item 4.8: Conflict of Interest

Members noted the NHMRC Conflict of Interest requirements and that the *Research Involving Human Embryos Act 2002* allows that regulations can be made under that act in relation to disclosure of Member's interests in matters being considered by the Licensing Committee.

Decision:

Committee to further consider whether regulation should be made.

Secretariat to obtain conflict of interest guidelines used by other authorities (VIC, SA and GTA) and prepare a proposal for consideration at the next meeting.

Item 4.9: Monitoring Powers

The Committee will be well briefed about all activities undertaken by Inspectors on its behalf.

Members noted the monitoring powers set out in the *Research Involving Human Embryos Act 2002* and the strategy proposed for use in implementing the monitoring powers. The strategy features a hierarchy of monitoring and compliance activities, escalating in severity ranging from communication and awareness through to criminal prosecution.

The emphasis will initially be on communication and awareness with the aim to encourage a culture of cooperative compliance. Inspections will also be undertaken in accordance with the legislation. Inspectors will act with sensitivity at all times.

The AFP has given a commitment to respond, where possible, to notifications of possible breaches, within a 24-hour period, should this become necessary. This assurance only applies to a situation where an inspector has exercised the power to secure a human embryo or a thing, during an inspection, that may afford evidence of a commission of an offence against the Act(s). All other referrals to the AFP for possible investigation of suspected serious non-compliance will be made in accordance with the Commonwealth Fraud Control Guidelines through the AFP Operations Monitoring Centres in the appropriate operational area.

Licence conditions will be detailed, clear, and not ambiguous.

The importance of a two-way exchange was highlighted, with Inspectors bringing information back to the Committee.

The impact of the Privacy Act on the activities of Inspectors, particularly with respect to the seeking of additional information from patient records, was discussed. Members were advised that inspectors have broad monitoring powers under the legislation, including to inspect any book, record or document on the premises. Patients will therefore need to be advised that Inspectors will be able to view consent records.

Decision:

To be considered further at next meeting.

Secretariat will work with an appropriate expert to develop a draft proposal outlining the steps required for organisations to fulfil requirements for a paper trail.

A formal selection process had taken place to provide a monitoring and compliance presence for the Committee. This process targeted people with specified qualifications. Inspectors will be appointed full time as Commonwealth officers, will be located in Canberra and will answer to the NHMRC Licensing Committee in accordance with the legislation. The Chairperson will formally appoint Inspectors via a written instrument of appointment.

Relevant State authorities would be notified if inspections were going to be carried out.

Decision:

The Committee Chairperson will appoint Inspectors.

Secretariat will facilitate the development of inspection processes for approval by the Committee.
Noted

Item 4.10: Reporting

Members noted the reporting requirements contained in the Acts.

A draft report was circulated and comments were sought from the Committee.

Decision:

Report to be finalised by the Committee for forwarding to the Minister by 30 June 2003.

Item 4.11: Database

Members noted progress in the development of the database required in accordance with the *Research Involving Human Embryos Act 2002*.

Committee to be kept informed of progress in the development of the database.

Each short statement recorded on the database to be cleared by the Committee.

Item 4.12: Review Procedures

The Committee was informed about appeal rights through the Administrative Appeals Tribunal (AAT). Members noted that all decisions made by the Committee are subject to review. The AAT will consider appeals from the perspective of the decision maker and review decisions on merit.

Item 5: COMMUNICATIONS

The Committee was informed of communications activities undertaken to date, in particular recent consultations held with key players in South Australia and Victoria. Similar sessions will be held in New South Wales and Queensland.

The committee agreed that the communication strategy should involve two-way dialogue with interest groups.

Decision:

Development of communications strategy to continue.

Item 6: ASSESSMENT PROCESS

The broad outline provided at the meeting for Members' consideration was noted. It was agreed that the Secretariat would review the document following discussion at the meeting, which included:

- a process for external review by both national and international experts;
- allocation of applications to a spokesperson(s) within the Committee;
- timeframes where appropriate.

Decision:

Continue development of broad assessment processes.

Item 7: CONSIDERATION OF APPLICATIONS

Five applications were considered by the committee:

309700 – Use of Excess Embryos for Training in ART
309701 – Improvement in laboratory conditions for embryo culture
309702 – Development of genetic methods for preimplantation genetic and metabolic evaluation of human embryos
309703 – Development of human embryonic stem cells
309704 – Development of human embryonic stem cells.

In each case the Secretariat was asked to seek additional information from the applicant to facilitate further consideration. It was also agreed that no licence should be issued for a period that exceeds the review of the legislation.

Decision:
Additional information to be sought from each applicant.

Duration of licence not to extend beyond the scheduled review of the legislation.

Item 8: MEETING SCHEDULE

The Committee to meet on 17 July 2003 and attend an Induction Day on 18 July.

Secretariat note: The meeting date was subsequently changed to 30 July, with Committee Induction on 31 July.

Item 9: OTHER BUSINESS

The paper entitled *Cryopreserved embryos in the United States and their availability for research* was noted.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-079

OUTCOME 9: HEALTH INVESTMENT

Topic: CREGART - REPORT TO COAG

Written Question on Notice

Senator Harradine asked:

Committee to revise the ethical guidelines on assisted reproductive technology (CREGART), a sub-Committee of AHEC, submitted a report to COAG on 4 April 2003. Please provide a copy of that report.

Answer:

As the *Report on Protocols to Preclude the Creation of Embryos Specifically for Research Purposes* was prepared for COAG at Minister Patterson's request, NHMRC is not at liberty to release the report. You may wish to pursue this matter through the Department of Prime Minister and Cabinet.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-080

OUTCOME 9: HEALTH INVESTMENT

Topic: CREGART - DETAILS

Written Question on Notice

Senator Harradine asked:

I understand CREGART was established in late 2002. Would you please provide details including:
(a) when and where they have met;
(b) what they have discussed;
(c) were there differing views expressed on issues? If so, please provide details; and
(d) copies of the minutes of the meetings.

Answer:

In September 2001, the Australian Health Ethics Committee (AHEC) undertook to revise the 1996 National Health and Medical Research Council's *Ethical guidelines on assisted reproductive technology* (1996 Guidelines).

The Committee to Review Ethical Guidelines on Assisted Reproductive Technology (CREGART) was established by AHEC and met for the first time on 20 November 2001.

Initial consultation was undertaken from September to November 2001, and sixty one submissions were received. AHEC considered that it was appropriate to delay further consultation on the draft guidelines until after the conclusion of Parliamentary debate on the *Research Involving Embryos and Human Cloning Bill 2002*. The draft revised guidelines were released for public consultation on 12 February 2003 and submissions closed on 28 March 2003. One hundred and nine submissions were received.

(a) CREGART held ten formal meetings during the period from November 2001 to May 2003, as follows:

- Meeting 1 – 20 November 2001, face-to-face meeting, Canberra
- Meeting 2 – 19 December 2001, teleconference
- Meeting 3 – 22 January 2002, face-to-face meeting, Canberra
- Meeting 4 – 19 and 20 February 2002, face-to-face meeting, Canberra
- Meeting 5 – 25 and 26 March 2002, face-to-face meeting, Canberra
- Meeting 6 – 18 and 19 April 2002, face-to-face meeting, Canberra
- Meeting 7 – 16 October 2002, teleconference
- Meeting 8 – 29 October 2002, teleconference
- Meeting 9 – 7 November 2002, teleconference
- Meeting 10 – 22 and 23 April 2003, face-to-face meeting, Sydney

(b) CREGART undertook two major tasks during the 2000 – 2003 triennium, namely:

- The revision of the 1996 Guidelines, including *Supplementary Note 5 – The human fetus and the use of human fetal tissue* 1983 (Supplementary Note 5).

- The Council of Australian Governments (COAG) at its meeting of April 2002 agreed to establish an ethics committee to report to the Council within 12 months, on protocols to preclude the creation of embryos specifically for research purposes with a view to reviewing the necessity for retaining the restriction on embryos created on or after 5 April 2002. In August 2002, Minister Patterson wrote to the Chair of AHEC requesting that AHEC add this task to the work program of its sub-committee CREGART and this request was accepted by AHEC on 9 September 2002.

(c) As is generally the case when complex issues are discussed, differing views were expressed on all issues being considered at the CREGART meetings.

(d) The minutes of CREGART meetings are not public documents, and are not provided for the following reasons:

- The minutes include detailed discussions of individual submissions, which are not public documents and cannot be released without the author's permission;
- The minutes represent CREGART's thinking at particular stages of development of the draft guidelines and thus do not necessarily represent final decisions, particularly with respect to those meetings held before public consultation took place; and
- The draft guidelines are undergoing significant changes as a result of public consultation and further consideration. Minutes of earlier meetings will not show these changes in development.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-081

OUTCOME 9: HEALTH INVESTMENT

Topic: NHMRC GRANTS - FEMALE ENDOCRINOLOGY GROUP

Written Question on Notice

Senator Harradine asked:

Please provide details of all NHMRC grants to the female reproductive endocrinology group and/or Professor Jock Findlay for the past two years.

Answer:

There is currently one grant being funded by the NHMRC in the area of female reproductive endocrinology. The details of the grant are as follows:

App ID:	Chief Investigator A	Duration and Grant Type	Scientific Title	Administering Institution	Total Budget
241000	Professor Jock Findlay	5 year Program Grant – January 2003 to December 2007	Hormonal regulation of reproduction in health and disease	Prince Henry's Institute of Medical Research	$7,425,000

In addition, Professor Jock Findlay is receiving funding in the form of a NHMRC Research Fellowship as follows:

App ID:	Chief Investigator A	Duration and Grant Type	Scientific Title	Administering Institution	Total Budget
169018	Professor Jock Findlay	1 year Research Fellowship – January 2001 to December 2001	Ongoing uncoupled research fellowship	Prince Henry's Institute of Medical Research	$100,631
198705	Professor Jock Findlay	5 year Research Fellowship – January 2002 to December 2006	Uncoupled research fellowship	Prince Henry's Institute of Medical Research	$748,000

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-094

OUTCOME 9: HEALTH INVESTMENT

Topic: MEDICAL GRADUATE PLACES FOR WA

Written Question on Notice

Senator Webber asked:

(a) Could the Minister confirm whether Western Australia will eventually be granted an additional 80 medical graduate places as announced in Canberra by the President of the Western Australian Branch of the AMA in May?

(b) How is it that the AMA is able to make this announcement, presumably after being briefed by the Department, before the Minister herself advises the people of Western Australia and the University of Western Australia and the University of Notre Dame Australia?

Answer:

(a) As part of the Government's Fairer Medicare Package, 234 new publicly funded medical school places are being made available each year from 2004. Western Australia is to receive 45 of these places.

(b) The Department has no comment to make on this matter.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-095

OUTCOME 9: HEALTH INVESTMENT

Topic: GP SHORTAGES - PERTH

Written Question on Notice

Senator Webber asked:

(a) How many doctors have surgeries in areas of GP workforce shortages in the Perth outer metropolitan area?

(b) How many people live in outer metropolitan Perth?

(c) What is the increase in the shortage of GPs in outer metropolitan Perth since 2002?

(d) What is the per capita access to GP services in the whole of metropolitan Perth in the past 12 months?

(e) What has been the net increase in GPs in the whole of metropolitan Perth in the past 12 months?

Answer:

(a) Approximately 343 full-time equivalent general practitioners provided services in the areas of Perth eligible for the More Doctors for Outer Metropolitan Areas Measure in the second quarter of 2003.

(b) The residential population for the areas at (a) above is 613,531.

(c) The full-time equivalent doctor to population ratio for the areas at (a) above has remained constant since 2002.

(d) In 2003-03 residents of Perth averaged 4.6 general practitioner services per person.

(e) Over the past two financial years the number of GPs in the Perth metropolitan area has decreased by 13. However, the number of full-time equivalent general practitioners has remained constant.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03 - 096

OUTCOME 9: HEALTH INVESTMENT

Topic: EXTRA DOCTORS AS PER BUDGET

Written Question on Notice

Senator Webber asked:

What are the numbers of extra doctors to be achieved by the measures announced in the Budget?

Answer:

Under the Fairer Medicare Package announced by the Prime Minister and Minister for Health and Ageing an additional 234 publicly funded medical school places will be made available each year from 2004.

In addition, under the Package an extra 150 general practitioner training places will be available each year from 2004.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-237

OUTCOME 9: HEALTH INVESTMENT

Topic: MORE DOCTORS FOR OUTER METROPOLITAN AREAS

Written Question on Notice

Senator McLucas asked:

(a) How much money has been spent to date on this initiative in each of the financial year?

(b) How much money has been diverted to other initiatives, and to which initiatives has the money been diverted?

(c) What is the revised forward estimates for the measure?

(d) How will the remaining funds be spent?

(e) Can you please provide a state-by-state breakdown of the numbers of doctors (GPs, specialists and registrars) who have signed up under this scheme?

(f) The Minister has recently announced that the Department would revise its guidelines for the outer metropolitan program to encompass more suburbs. How were these areas selected? What were the criteria?

Answer:

(a) The More Doctors for Outer Metropolitan Areas Measure began operation in January 2003. Total expenditure under the Measure in 2002-03 is estimated to be around $2.6 million.

(b) An amount of $15.4 million has been reallocated from the Measure over the three years beginning in 2003-04. This is being used to assist in funding the initiative in the Fairer Medicare Package relating to the provision of additional nurses and allied health professionals for general practices in urban areas of workforce shortage.

(c) The table below shows the funding allocation for the More Doctors for Outer Metropolitan Areas Measure for the 3 years from 2003-04.

	2003-04 $m	**2004-05 $m**	**2005-06 $m**
More Doctors for Outer Metropolitan Areas Measure	14.0	19.5	19.5

(d) The remaining funding will be spent implementing the following four components of the More Doctors for Outer Metropolitan Areas Measure:

- Outer Metropolitan Relocation Incentive Grants;
- Outer Metropolitan (Other Medical Practitioners) Relocation Incentive Program;
- Outer Metropolitan Registrars Program; and
- Outer Metropolitan Specialist Trainees Program.

(e) This information, as at June 2003, is set out below.

State	**GPs and Specialists***	**GP Registrars and Specialist Trainees***	**Total**
NSW	12	4	16
Victoria	20	6	26
Queensland	14	3	17
South Australia	*	*	4
Western Australia	3	5	8
Tasmania	*	*	4
Total			**75**

* Groups have been combined and totals only provided for some States due to small cell size.

In addition, as at 20 June 2003, a further 39 applications for participation in the Measure had been received and are currently being processed.

(f) These areas were selected on the basis that they contained locations with medical workforce shortages and exhibited one or more of the following characteristics:

- Are generally continuous with the existing outer metropolitan area;
- Are situated within a growth corridor;
- Form a band adjacent to the inner boundary of an outer metropolitan area;
- Exhibit an ‘island effect’. An ‘island effect’ occurs where inner metropolitan areas surround an area with population characteristics that would normally define it as an outer metropolitan area. For example, this might occur where an area of land that was undeveloped in 1991 is located in an inner metropolitan area and has subsequently been developed.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-143

OUTCOME 9: HEALTH INVESTMENT

Topic: GRANT 113949 – INQUIRY INTO UNAUTHORISED EXPENDITURE

Hansard Page: CA 497

Senator Carr asked:

(a) Can you advise me as to whether, in the council's view, there is a need for further action in the recovery of moneys?
(b) Can you also establish the factual circumstances? – whether or not there has been an unauthorised withdrawal and expenditure of funds.

Answer:
(a) Not at this point, pending receipt of the final report on this grant.
(b) The question of whether there has been an unauthorised expenditure of funds at any time during the grant is a matter which the Chief Investigator and university need to determine. We are writing to them to remind them of their responsibilities and seeking their advice on the outcome.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2, 3 & 5 June 2003

Question: E03-144

OUTCOME 9: HEALTH INVESTMENT

Topic: GRANT 209656 - PROFESSOR BRUCE HALL

Hansard Page: CA 497

Senator Carr asked:

Has the department been aware of any findings within the university that Professor Hall stated a material or significant falsehood with an intent to deceive?

Answer:
No.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-257

OUTCOME 9: HEALTH INVESTMENT

Topic: CAPITAL CITIES VS NON-METROPOLITAN AREAS

Hansard Page: CA 500

Senator McLucas asked:

Can you provide a list of where applications have been made for exemptions from Medicare provider number restrictions from overseas trained doctors for the last three years and how many were successful/unsuccessful?

Answer:

The following table provides information on applications, under section 19AB of the *Health Insurance Act 1973,* for Medicare approvals of overseas-trained doctors for the period 1 July 2001 to 20 June 2003.

State/Territory	Number of Applications Approved	Number of Applications Not Approved	Total Number of Applications
ACT	50	0	50
NSW	1519	19	1538
NT	334	0	334
QLD	3802	54	3856
SA	850	8	858
TAS	183	3	186
VIC	1934	26	1960
WA	1305	11	1316
Total	**9977**	**121**	**10098**

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-258

OUTCOME 9: HEALTH INVESTMENT

Topic: PROVIDER NUMBERS FOR OVERSEAS DOCTORS

Hansard Page: CA 501

Senator McLucas asked:

(a) How many of the 23 overseas trained doctors that have been granted an exemption to access Medicare benefits in the Townsville and Thuringowa area? Please show the separation.

(b) Were there other applications that were not successful?

Answer:

(a) and (b) Table 1 below provides the separation between Townsville and Thuringowa of applications for Medicare access approval under section 19AB of the *Health Insurance Act 1973.* All of the applications were successful in both Townsville and Thuringowa.

Table 1

Doctor Number	Number of Applications in Townsville	Number of Applications in Thuringowa	Total Number of Applications
1	3		3
2	6		6
3		1	1
4		1	1
5	1		1
6	8		8
7	3		3
8		2	2
9	3		3
10	3	3	6
11	3		3
12	1		1
13	1		1
14	1		1
15	1		1
16	1		1
17	2	1	3
18	2	1	3
19	1		1
20		1	1
21	1		1
22	1		1
23	1		1
Total	**43**	**10**	**53**

Notes:

1. Some doctors have Medicare approvals for more than one practice.
2. The approvals relate to the period from July 2001 to April 2003 and some of them have expired.
3. The Department is unable to supply the names of doctors nor the practices where they are working, due to privacy constraints in the *Health Insurance Act 1973*.

Senate Community Affairs Legislation Committee

ANSWERS TO ESTIMATES QUESTIONS ON NOTICE

HEALTH AND AGEING PORTFOLIO

Budget Estimates 2003-2004, 2-3 & 5 June 2003

Question: E03-259

OUTCOME 9: HEALTH INVESTMENT

Topic: AFTER HOURS MEDICARE PROVIDER NUMBERS

Hansard Page: CA 502

Senator McLucas asked:

Did the Department talk to the Townsville Division of General Practice before approving the three after-hours provider numbers?

Answer:

No.

The three overseas trained doctors at 'The Doctors Clinic' Townsville were given agreement to operate with Medicare access under the provisions of section 19AB of the *Health Insurance Act 1973*.

The Health Insurance Act Section 19AB Guidelines require the Department to make an assessment on whether to place an overseas trained doctor on the basis of overall community need for medical services in a local area. This criterion was able to be established without the need for consultations with the Townsville Division of General Practice.